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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

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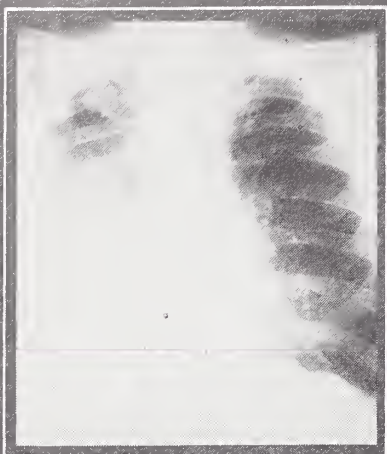
AUG 1



Rabies Prophylaxis—A Primer
See page 27.

294510

HERE Pleural effusion




Wherever it hurts,
Empirin Compound with
Codeine usually provides
the relief needed.

HERE Biliary calculi



In general, only pain so severe
that it requires morphine is
beyond the scope of
Empirin Compound with Codeine.

 **prescribing convenience:**
up to 5 refills in 6 months,
at your discretion (unless
restricted by state law); by
telephone order in many states.

Empirin Compound with
Codeine **No. 3**, codeine
phosphate* 32.4 mg. (gr. ½);
No. 4, codeine phosphate*
64.8 mg. (gr. 1). *Warning—
may be habit-forming. Each
tablet also contains: aspirin
gr. 3½, phenacetin gr. 2½,
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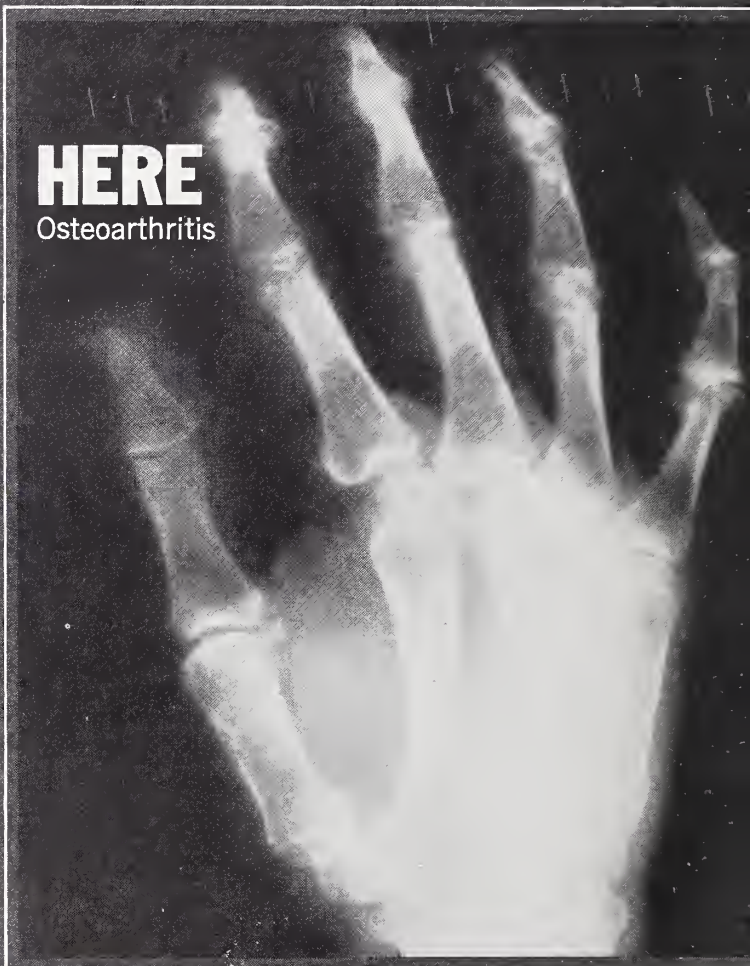


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North Carolina 27709

WHEREVER IT HURTS

HERE
Osteoarthritis



EMPIRIN COMPOUND c CODEINE

#3, codeine phosphate* (32.4 mg.) gr.
#4, codeine phosphate* (64.8 mg.) gr.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

Blue Cross-Blue Shield New Carrier for State Employees Program

Effective July 1, 1973, the administration of the health care program of more than 120,000 state of Illinois employees and dependents has been placed with Blue Cross and Blue Shield Plans.

The special State contract provides the same broad scope of benefits that State employees have had for the past 18 months.

Payment for employees' claims is based on Usual and Customary fees of physicians. Co-insurance and deductibles are incorporated in the program at varying levels. Options are made available to each employee to cover dependents at the same or a reduced level of benefits.

NOW THERE ARE TWO PAYMENT OFFICES
FOR STATE OF ILLINOIS CLAIMS

(Note the Geographic division)

NORTHERN AREA—Chicago office (no change) →

SOUTHERN AREA—New Springfield claim office

New Springfield Claims Center

One of the most important features of the new program for State of Illinois employees will be the payment of downstate claims from our new operations office in Springfield. Local control will result in speedier payment and more efficient service for our downstate physicians and State employees.

Only State of Illinois claims will be paid from the Springfield office. All other Blue Shield claims are to be forwarded to Chicago.

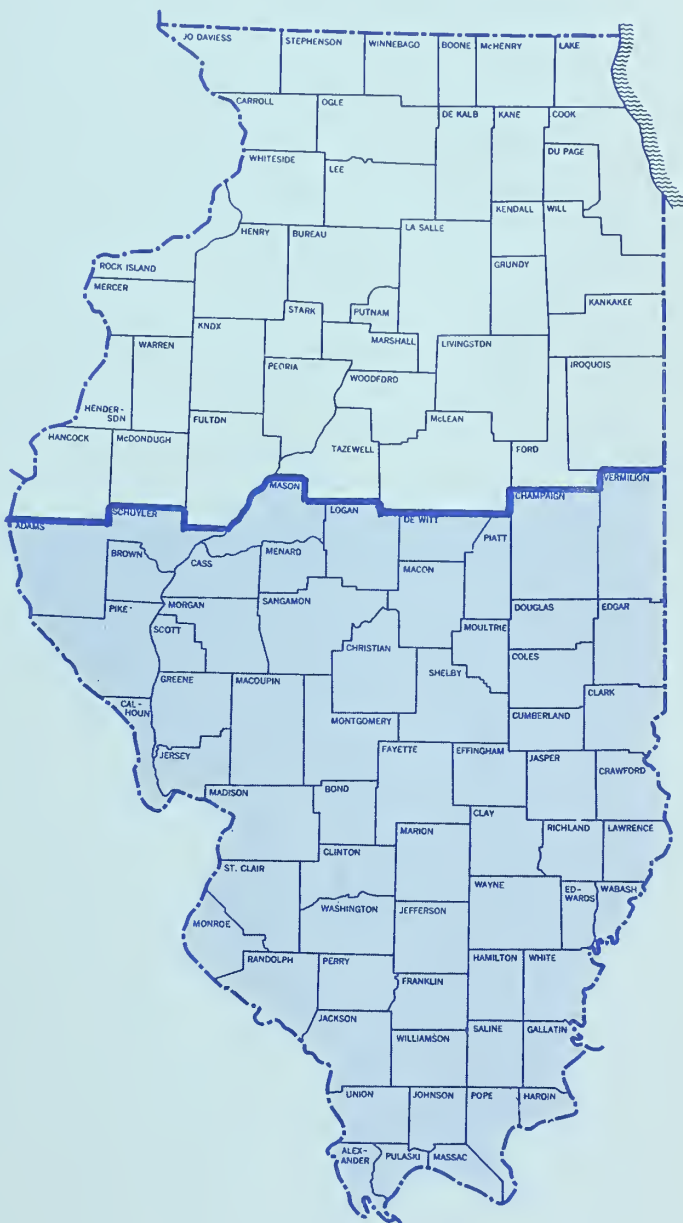
If your office is located in the Southern area indicated on our map (right) send Blue Shield claims for State of Illinois members to:

Blue Shield Plan
525 West Jefferson Street
Suite 207
Springfield, Illinois 62702

Special claims envelopes are being printed for distribution in the downstate area. Physicians in the Northern half of the State should continue to send claims to the Chicago office.

(Continued on following page)

(This report is a service to the physicians of Illinois)



COMPLETE INFORMATION NEEDED

PHYSICIAN'S SERVICE REPORT

TO SPEED BLUE SHIELD PAYMENTS
TO YOU, MAIL TO



BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE
222 N. DEARBORN ST., CHICAGO, ILLINOIS 60601
661-4200

Patient's Name JOHN DOE Age 40 Sex Male
(Type or Print)

Subscriber's Name JOHN DOE
Address 1973 South Willow
Springfield, Illinois 62701
City, State & Zip Code

42500 GROUP NO. 344-16-7571 SUBSCRIBER NO.

Is This a Workmen's Compensation Case?
Yes ☐ No ☐ Possibly ☐

1. ☐ Hospital Inpatient 2. ☐ Hospital Outpatient

WHERE WAS SERVICE RENDERED?

Does The Patient Have Other Group

Physician's Service Report Form and Special Identification Card

When completing Physician's Service Reports for the State of Illinois employees, be sure to enter both the group number 42500 and the complete Social Security Number in the box as shown in the sample above.

For immediate recognition of members of this State group, special identification cards have been issued. A sample card is shown on the right:

- Please note the group number of all State members is 42500.
- Replacing the usual "subscriber number" is the employee's Social Security Number.
- Both these numbers are important for identification and to prevent payment delays.

Blue Cross Blue Shield STATE OF ILLINOIS
Employees Group Insurance Program

John J. Doe
Employee's Signature

State Department
Employing Agency

John J. Doe
Employee

Code 7-1-73 Effective Date

42500 Group Number
344-16-7571 Social Security Number

The Subscriber named above is entitled to all benefits as described in the certificate issued by: BLUE CROSS and BLUE SHIELD
233 N. Michigan Ave., Chicago, Ill. 60601
227 N. Wyman St., Rockford, Ill. 61110

EB-1000 6-73

ASK BLUE SHIELD . . . ABOUT MEDICARE

SSA Certification Continued on Portable X-ray Services

The Social Security Administration approved the participation of the following portable X-ray services under the Medicare program:

Chicago Portable X-Ray Service
6411 North Troy
Chicago, Illinois 60645
Provider No. 14-9800

Home X-Ray Service, Inc.
5935 West Addison Street
Chicago, Illinois 60634
Provider No. 14-9802

Johnson Paramedical Service
1100 Geneva Road, Apt. 42-B
St. Charles, Illinois 60174
Provider No. 14-9806

Mobile X-Ray, Inc.
1580 Cora Street
Des Plaines, Illinois 60018
Provider No. 14-9804

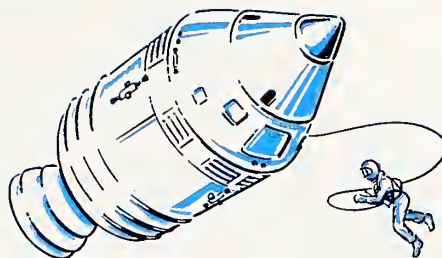
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Portable X-Ray Service
6612 West Cermak Road
Berwyn, Illinois 60402
Provider No. 14-9805

Reliable Portable X-Ray
10039 Longwood Drive
Chicago, Illinois 60643
Provider No. 14-9803

(This report is a service to the physicians of Illinois)



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.


2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.



WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



If she
comes up
with otitis
externa...

Coly-Mycin[®] S/Otic

WITH NEOMYCIN AND HYDROCORTISONE
(colistin sulfate — neomycin sulfate — thonzonium
bromide — hydrocortisone acetate otic suspension)

- ☐ anti-inflammatory/antipruritic
- ☐ broadly anti-infective
 - vs. many Gram-negative invaders...
including *Pseudomonas aeruginosa*.
 - vs. many Gram-positive invaders...
including *Staph. aureus*.
- ☐ normalizes pH

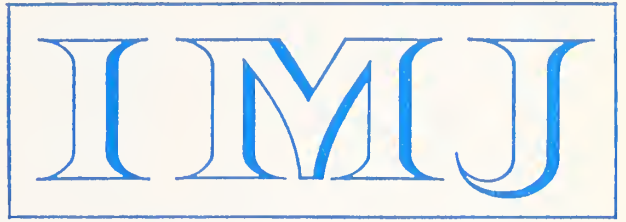
Each ml contains: Colistin base activity, 3 mg (as the sulfate); Neomycin base activity, 3.3 mg (as the sulfate); Hydrocortisone acetate, 10 mg (1%); Thonzonium bromide, 0.5 mg (0.05%). Polysorbate 80, acetic acid, and sodium acetate in a buffered aqueous vehicle. Thimerosal, 0.002%, added as a preservative.

Indications: Coly-Mycin S Otic with Neomycin and Hydrocortisone is indicated in the treatment of acute and chronic external otitis due to or complicated by bacterial and/or fungal infections caused by susceptible organisms. It is also indicated for the prophylaxis of "swimmer's ear." **Contraindication:** A history of sensitivity to any of the components or in tubercular, fungal and most viral lesions, especially herpes simplex, vaccinia and varicella. **Precautions:** If sensitivity or irritation occurs, medication should be discontinued promptly. Overgrowth of resistant organisms is possible. Use with care in cases with perforated eardrum or in long standing otitis media because of the possibility of ototoxicity caused by neomycin. There are articles in the current medical literature that indicate an increase in the prevalence of persons sensitive to neomycin. **Adverse Reactions:** A low incidence of mild burning or painful sensation in the ear has been reported. Such local effects do not usually require discontinuance of medication. Sensitivity reactions were reported in a few instances. **Administration and Dosage:** After the ear has been completely cleansed and dried, Coly-Mycin S Otic with Neomycin and Hydrocortisone should be instilled (a sterile dropper is provided) into the canal, or applied to the surface of the affected ear. Shake the suspension well before using. The recommended therapeutic dosage is four (4) drops, 3 times a day; prophylactically, four (4) drops before and after swimming. Until acute pain has subsided, it may be preferable or necessary in some patients to pack the ear with a cotton wick saturated with Coly-Mycin S Otic with Neomycin and Hydrocortisone. The wick should be kept wet at all times. The patient should be instructed to avoid contaminating the dropper, especially with the fingers. Coly-Mycin S Otic with Neomycin and Hydrocortisone is stable for eighteen (18) months at room temperature; however, prolonged exposure to higher temperatures should be avoided. **Supplied:** Coly-Mycin S Otic with Neomycin and Hydrocortisone is available in bottles containing 5 ml or 10 ml. Each ml contains 3 mg of colistin base activity (as the sulfate), 3.3 mg of neomycin base activity (as the sulfate), 10 mg of hydrocortisone acetate, 0.5 mg of thonzonium bromide, polysorbate 80, acetic acid and sodium acetate. A small amount (0.02 mg/ml) of thimerosal has been added as a preservative. Each package contains a sterile dropper. Full information is available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Co.
Morris Plains, N.J. 07950

CMD-GP-318-BW



Illinois Medical Journal

JULY, 1973

Vol. 144, No. 1

CONTENTS

-
- 16 Abstracts of Board of Trustees Meeting
-

Special Articles

- 67 The Story of Rheumatology in Chicago
Eugene F. Traut, M.D.
- 76 Disability Insurance Under Social Security
Harry E. Grant, M.D.
-

Clinical Articles

- 27 Rabies Prophylaxis-A Primer
Robert J. Rubin, M.D.
- 30 Studies of Histoplasmosis in Two Illinois Communities
Walter F. Buell, M.D., Fred E. Tosh, M.D., M.P.H., Russell J. Martin, D.V.M., M.P.H., Paul R. Schnurrenberger, D.V.M., M.P.H., and Norman J. Rose, M.D., M.P.H.
- 34 Pediatric Perplexities: Accidental Ingestion
Ruth Andrea Seeler, M.D.
- 37 Nonketotic Hyperglycemic Coma in Infancy
Ronald D. Greenwood, M.D., Howard S. Traisman, M.D., Mathew M. Steiner, M.D., and Sirus A. Hadaawi, M.D.
- 44 Delayed Ovulation
Martin B. Wingate, M.D., W. S. Michael Arrata, M.D., and Leslie Iffy, M.D.
- 64 The Use and Abuse of Antibiotic and Chemotherapeutic Remedies
Martin H. Seifert, M.D.
-

Surgical Grand Rounds

- 41 Ulcer Recurrence After Vagotomy and Pyloroplasty
John M. Beal, M.D., Editor
-

Trauma Center

- 56 Traumatic Rupture of Thoracic Aorta
Edward H. Sharp, M.D., William D. Cox, M.D., and Randall Mullin, M.D.

(Contents continued overleaf)

CONTENTS (continued)

Features

- 21 President's Page
- 22 Clinics for Crippled Children
- 36 Viewbox
- 48 New Pharmaceutical Specialties
- 52 Doctor's News
- 55 Editorials
- 60 Doctor's Library
- 62 EKG of the Month
- 69 Pulse of the Doctor's Wife
- 71 Illinois Society, American Association of Medical Assistants
- 72 Obituaries
- 78 Physician Recruitment Program
(Cover by Mike Ahearn)

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IN ASTHMA IN EMPHYSEMA



*optional
therapy*



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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications** are listed above. **MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with $\frac{1}{2}$ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula *First choice*

MUDRANE-2 *When ephedrine is too exciting or is contraindicated*

MUDRANE GG *During pregnancy or when K.I. is contraindicated or not tolerated*

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WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



The natural way



Premarin[®]

BRAND OF
CONJUGATED ESTROGENS TABLETS, U.S.P.

**contains
only
natural estrogens
...no synthetics
or
supplements**

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.

"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration.

If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia

gastrointestinal symptoms such as abdominal cramps and bloating

breakthrough bleeding, spotting, unusually heavy withdrawal bleeding

(See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement

reactivation of endometriosis

possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males

edema

aggravation of migraine headaches

change in body weight (increase, decrease)

headache

allergic rash

hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each purple tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each yellow tablet contains 1.25 mg., in bottles of 100 and 1,000.

Also in unit dose package of 100.

No. 867—Each red tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each green tablet contains 0.3 mg., in bottles of 100 and 1,000.

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New York, N.Y. 10017

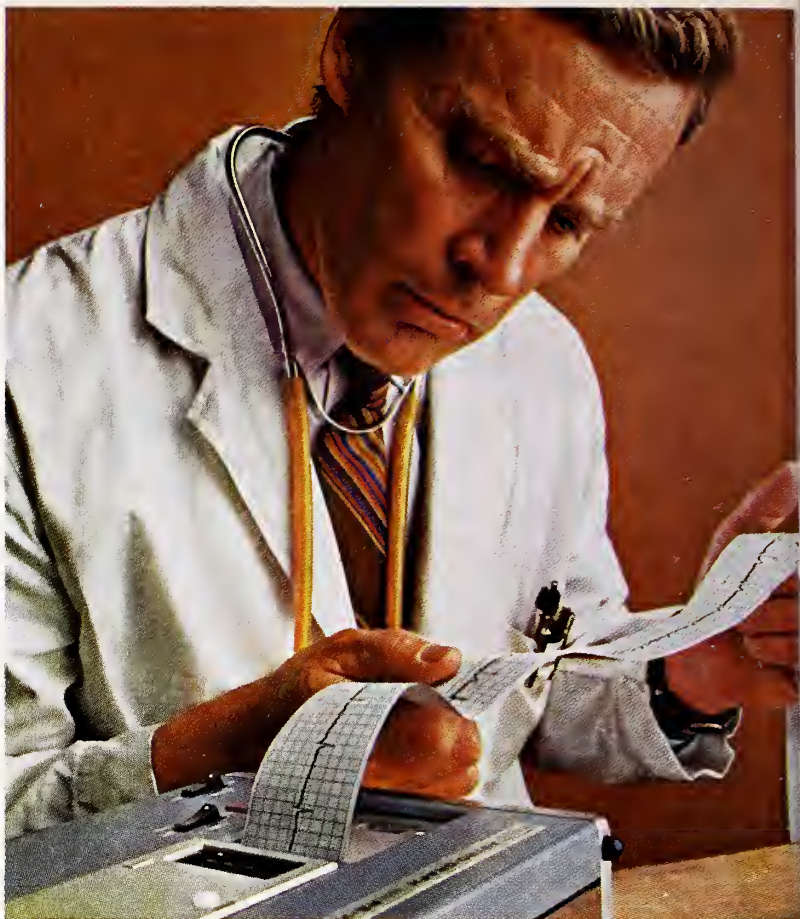
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For more than thirty years
PREMARIN (Conjugated
Estrogens Tablets, U.S.P.)
has been prepared with natural
equine estrogens exclusively—
without synthetic estrogen
supplements. For more than
thirty years it has provided
the complete estrogen
complex—in the proportions
found in its natural source.
And for more than thirty years
PREMARIN has enjoyed an
unparalleled record of clinical
efficacy and acceptance.

PREMARIN. The only leading
estrogen tablet that meets all
U.S.P. specifications for con-
jugated estrogens. Assurance
of quality for you and your
patients.

PREMARIN...naturally.

When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When the symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have

Before prescribing, please consult complete product information a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of drug and similar to those seen with barbiturates, have been reported. Use with any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over 6 years of age, limit to smallest effective dosage (initially 10 mg or less per day) to prevent ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions.

anic basis and that reduction of excessive anxiety and emotional overreaction could be medically beneficial.

The benefits of antianxiety therapy

Antianxiety medication, when used to complement counseling and reassurance, could be both effective and comparatively free from undesirable side effects. More than 20 years of extensive clinical experience has demonstrated that Librium (chlordiazepoxide HCl) fulfills these requirements with a high degree of consistency. Because of its wide margin of safety, Librium may generally be administered for extended periods, at the physician's discretion, without diminution of effect or need for increase in dosage. (See Summary of prescribing information.) If cardiovascular drugs are necessary, Librium may be used concomitantly whenever anxiety is a clinically significant factor. (See Precautions.) Librium should be discontinued when anxiety has been reduced to appropriate levels.

For relief of
excessive anxiety
adjunctive

Librium® 10 mg
(chlordiazepoxide HCl)
1 or 2 capsules t.i.d./q.i.d.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

presence of impaired renal or hepatic function. Paradoxical reactions (excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established conclusively.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, constipation, extrapyramidal symptoms, increased and decreased salivary gland activity, all infrequent and generally controlled with dosage reduction; changes in ECG patterns (low-voltage fast activity) may appear during and after treatment. Blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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and 25 mg. of hydrochlorothiazide.

GETS THE WATER OUT IN EDEMA

BRINGS DOWN BLOOD PRESSURE IN HYPERTENSION^{*}

SPARES POTASSIUM IN BOTH

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide,' check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides

are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that the courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock all brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Abstracts of Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

May 19-20, 1973

Chicago

Alexian Brothers Medical Center Conflict

ISMS will request Joint Commission on Hospital Accreditation to investigate the recent action of Alexian Brothers Medical Center in which the hospital revised its medical staff bylaws without having them formally adopted by the physicians. An appeal to the AMA-AHA Task Force also is planned. Meanwhile, ISMS has postponed legal action pending completion of these investigations.

PSRO

Because legal counsel has advised that neither ISMS nor IFMC would qualify as a PSRO under PL 92-603, a separate organization is being planned to act as the prime contractor for PSRO in Illinois, with IFMC and its affiliate local FMC's as the administrative arm. The Board of Trustees authorized Drs. Frank J. Jirka, Jr., William Lees and Fredric Lake to attend an AMA-sponsored meeting on PSRO in Washington, May 23.

Relative Value Study

Drs. Clifton Reeder, Robert Becker, Theodore Grevas and J. Lloyd D'Silva have been appointed to a special committee to study the cost and methods of a possible revision of the ISMS Relative Value Study as directed by the 1973 House of Delegates.

Conference on Physicians and Schools

Dr. Daniel Pachman will represent ISMS at the National Conference on Physicians, Schools and Communities, which the AMA is conducting October 10-11 at the LaSalle Hotel, Chicago.

Distribution of Record on Alcoholism

The Board authorized distribution of 1,000 copies of a phonograph record on alcoholism made available by Pfizer Laboratories. Members will be charged \$1.00 to cover the cost of postage and handling.

Peer Review

To avoid having peer review committees bogged down with minor disputes, the Board of Trustees has directed its Council on Economics and Peer Review to develop a statement insisting that insurance carriers prove they have exhausted all means of dealing directly with the physician involved before a problem will be accepted for peer review.

The Sick Doctor Problem

A new committee to consider the problem of physicians with psychiatric disorders, including alcoholism and drug dependence, will consist of the president, president-elect, immediate past president, chairman of the Board of Trustees, chairman of the Governmental Affairs Council and two members of the Council on Mental Health and Addiction.

Hospital Satellites

The Board of Trustees will appoint an ad hoc committee to study the matter of "satellite facilities" being established by hospital and non-physician groups for the practice of medicine and related services away from the recognized and approved location.

Principle of Confidentiality

The Medical-Legal Council will study the principle of confidentiality with references to state law and federal regulations.

1974 Annual Meeting

By official action, the Board voted to conduct the 1974 annual meeting April 3-6 at the Conrad Hilton Hotel. Additional fees will be charged for postgraduate courses to offset the loss of income caused by a declining number of exhibits at the meeting. The Board's approval is contingent upon the understanding that ISMS will not be responsible for any losses incurred by the Midwest Clinical Conference unless a joint budget acceptable to ISMS and CMS is approved by both organizations and a uniform system of accounting is developed. A subcommittee of the Joint Management Committee will be appointed to implement the system.

Council Appointments

Because the newly-revised ISMS bylaws state that "no member of a council may serve more than five consecutive one-year terms," the Board faced the problem of reconstituting the society's entire council system. Rather than wipe out existing councils, it was decided to appoint new chairmen to replace those who had reached the five-year maximum tenure, keeping the retiring chairmen as members of the respective councils this year, with other council members being replaced gradually. Although medical students have been on ISMS committees for several years, interns and residents will be appointed to councils this year for the first time.

Formation of the new ISMS Council on Affiliate Societies was begun with the Board ratifying the names of four specialty society representatives nominated by their respective organizations. About 15 specialties are expected to be represented when the council is complete. In addition to those groups already recognized, the Chicago Society of Allergy will be invited to name a representative to this council.

Areawide Emergency Medical Services

Legal counsel was directed to meet with representatives of the Illinois Department of Public Health and to prepare an abstract that will clarify the existing law and department regulations implementing the Areawide Emergency Medical Services Act, which seems to be a source of confusion for most physicians and hospitals. The Board will act to establish better liaison between its Emergency and Disaster Medical Service Committee and state EMS officials.

Student Memberships

Having been informed that the Chicago Medical Society has amended its bylaws to provide for student membership, the Board agreed to appoint a student to the Joint CMS-ISMS Recruitment Committee. By official action, the Board is requesting its Committee on Constitution and Bylaws to eliminate the SAMA membership prerequisite for students applying for membership in ISMS.

In a related matter, the Board approved the underwriting of travel expenses for two medical students and two residents attending the AMA annual meeting

(Continued on page 81)

When irritable colon feels like this



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Gastroenteritis, colitis, gastritis or duodenitis can produce spasm or hypermotility, gas distention and discomfort. But Kinesed can provide a balanced formulation to relieve these symptoms:

- ☐ belladonna alkaloids—for the hyperactive bowel
- ☐ simethicone—for accompanying distention and pain due to gas
- ☐ phenobarbital—for associated anxiety and tension

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other

atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

Children 2 to 12 years: One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.



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When attempts are made to probe him
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sixty per cent over its normal size...
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How Can You Help?



Our poor are not receiving adequate health care—

Why?

Because the poor are NOT coming to us, and to other health professionals, for the care we are willing, able—AND WAITING—to give to them.

Too often, the poor do not know where to go for help. It is time for the physicians of Illinois, through ISMS and their county medical societies, to begin an intensive educational program.

We must tell the poor WHERE and HOW to get help.

More than 40 organizations and agencies which are working to alleviate the problems of Chicago's poor have asked for our guidance.

Recently, ISMS officers and members of the society's Committee on Health Care of the Poor met with spokesmen for community organizations, health agencies, volunteer groups and government. Our goal was to determine how the medical profession can attack the health and medical problems of a large and unfortunate segment of the city's population.

In the three and one-half hour dialog we defined major obstacles to providing quality health care for minority groups, the elderly, and those from rural areas who have difficulty adjusting to urban life. They are: cost of care, shortages of health care personnel, inadequate health education, and environmental conditions.

But singled out as the major barrier was the lack of coordination of programs and services, and difficulties in disseminating health care information. Spokesmen maintained that because of a lack of coordination and information, the poor are unaware of care which is available to them and many agencies do not know the total health care picture—even in areas they serve. This lack of coordination is also responsible for a saturation of services in some areas and an alarming scarcity in others.

As a result of the hearing, the ISMS Committee on Health Care of the Poor is exploring ways to coordinate these services. Specifically, the committee is seeking to determine the feasi-

bility of a clearing house to make information about health care readily available to residents in all parts of the city.

Ideally, such a service would operate a 24-hour "hotline" telephone enabling residents to call for information about health services near them—for treatment of drug abuse, alcoholism, mental depression, venereal disease and a wide range of other problems.

The "hotline" service would be extensively publicized in all possible media, including radio, television and press—especially ethnic publications which reach large segments of the poor.

However, this pilot program—if successful—would only scratch the surface. I believe we must also increase our efforts to meet the health care needs of thousands of poor and underprivileged in other urban as well as rural sections of Illinois.

What can you do?

You can visit your county health department and find out what the health care needs are in your area.

If your county does not have a health department, urge your colleagues to take the lead in organizing one.

Discuss health education problems with school officials, with teachers, even students. What are the problems in your school district—drug abuse? VD? Poor nutrition? And what can you and your county medical society do about them?

Talk to community leaders, parents, teachers, businessmen, clergymen and civic groups. They'll appreciate your interest, and they may have some interesting things to tell you.

Ask your patients for their opinions about community health care. Is there a need in your town for marital counseling? For a drug withdrawal center? For birth control information? If the answer is yes, help to get programs started to meet these needs.

Your community needs your help. ◀

William C. Schuman M.D.

Unity + Strength = Effectiveness

Clinics For Crippled Children Listed For August

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- August 1 Hinsdale - Hinsdale Sanitarium
- August 1 Carlinville - Carlinville Area Hospital
- August 2 Sterling - Sterling Community Hospital
- August 2 Lake County Cardiac - Victory Memorial Hospital
- August 7 East St. Louis - Christian Welfare Hospital
- August 8 Springfield Pediatric-Neurological - Diocesan Center
- August 8 Champaign-Urbana - McKinley Hospital
- August 9 Kankakee - St. Mary's Hospital
- August 9 Springfield - St. John's Hospital
- August 10 Chicago Heights Cardiac - St. James Hospital
- August 13 Peoria Cardiac - St. Francis Children's Hospital
- August 14 Peoria - St. Francis Children's Hospital
- August 14 East St. Louis - Christian Welfare Hospital
- August 15 Chicago Heights - St. James Hospital
- August 16 Elmhurst Cardiac - Memorial Hospital of DuPage County
- August 16 Bloomington - Mennonite Hospital
- August 16 Rockford - Rockford Memorial
- August 21 Rock Island - Moline Public Hospital
- August 21 Belleville - St. Elizabeth's Hospital
- August 22 Aurora - St. Joseph Mercy Hospital
- August 22 Springfield Pediatric-Neurological - Diocesan Center
- August 24 Evanston - St. Francis Hospital
- August 24 Chicago Heights Cardiac - St. James Hospital
- August 27 Peoria Cardiac - St. Francis Children's Hospital
- August 28 Peoria - St. Francis Children's Hospital

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T₄) and Sodium Liothyronine (T₃). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T₄ and T₃ in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T₃ ¹³¹I resin sponge uptake, T₃ ¹³¹I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T₄ and T₃ is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



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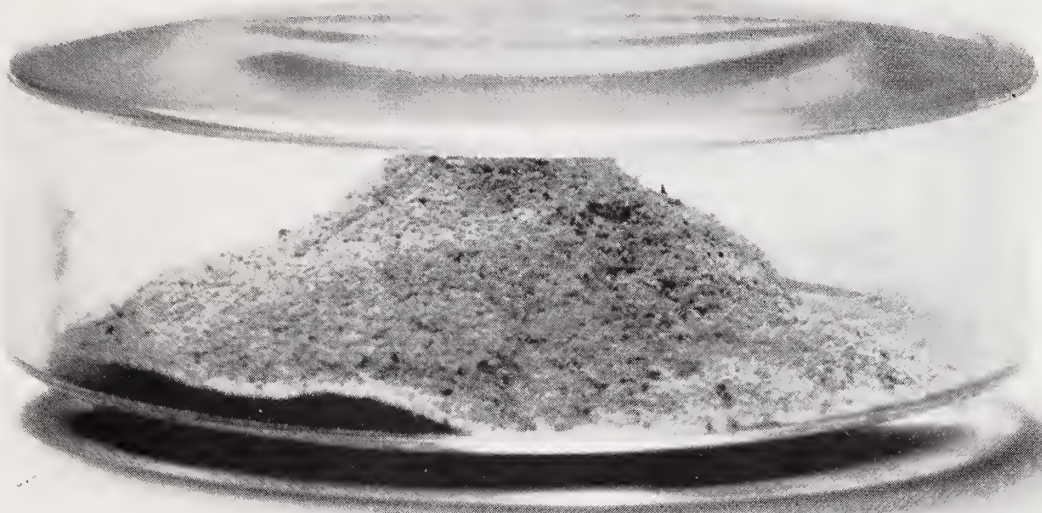
Then, Proloid is chemically and biologically assayed to assure consistent metabolic activity from batch to batch. The T_4 and T_3 content of every dose is blended for optimal thyroid replacement.

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nothing to chance



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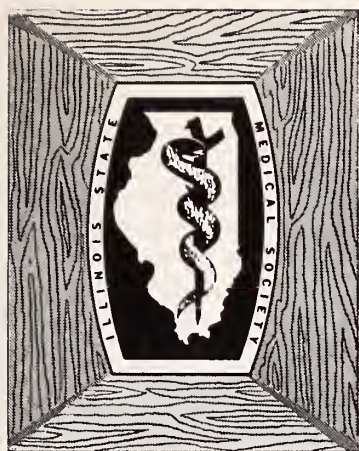
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Rabies Prophylaxis—A Primer

BY ROBERT J. RUBIN, M.D.

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Since ancient times the halycon days of summer during the helical rising of the “dog star” Sirius have been referred to as “dog days,” when it was known that dogs were likely to have “spells of madness.”¹ The ancients recognized the relationship between these “spells of madness” in animals and hydrophobia or rabies in men bitten by these “mad” animals. Today the problem of animal bites is great. The Center for Disease Control (CDC) estimates that each year 2 million Americans are bitten by animals. How to protect them from a disease that is nearly always fatal is a question faced by the physicians who must care for them.

A person is exposed to rabies when he comes into contact with live rabies virus, generally by the bite of a rabid animal. There have been rare reports of persons developing clinical rabies after “non-bite” exposures, such as from licks by rabid animals, the air in caves infested with rabid bats, and breathing aerosolized rabies virus in the laboratory. Not all exposures to rabies virus result in clinical illness and death, even if the patient is untreated. As in other infections, size of inoculum, virulence of the organism, and host defenses, both local and systemic, apparently are important factors in determining whether or not illness will occur. The physician must assume, however, that all exposures will lead to illness and probably death if the patient is untreated.

What should a physician do when confronted with a person who has recently been bitten by an animal? The answer is deceptively simple: practice good medicine by taking a careful

history and performing a physical examination. The physician must then evaluate the subjective and objective information obtained and formulate his plan of therapy. To do this the physician must know the species of animal involved, its condition at the time of the bite, its vaccination status, circumstances surrounding the bite (provoked or unprovoked), and the local epizootiology of rabies in his area.

In the past, domestic animals accounted for the majority of cases of animal rabies; for example, in 1946 there were more than 8,000 cases of rabies in dogs. As a result of an active immunization program for domestic animals, there were only 232 cases of rabies in dogs in 1972. In spite of this dramatic decrease, most of the humans who take antirabies prophylaxis do so because of bites by dogs and cats.

The major reservoir of rabies today is wild animals, such as skunks, racoons, foxes, and bats. These species accounted for more than 75% of all reported cases of animal rabies in 1972.² The last known case of human rabies caused by a domestic animal bite occurring in the United States was in 1965.

In Illinois, in 1972, there were 277 reported cases of animal rabies. Of these, 86% were in wild animals, with striped skunks accounting for 91% of the wild animal cases. There were only five reported cases of rabies in dogs in 1972.³ The importance of knowledge of the local epizootiology is illustrated by a report from the Illinois Department of Public Health which indicated that in 1967-1968, 20% of persons vaccinated for rabies had been exposed to a

Post Exposure Antirabies Guide

The following recommendations are only a guide. They should be used in conjunction with knowledge of the animal species involved, circumstances of the bite or other exposure, vaccination status of the animal, and presence of rabies in the region.

Animal and Its Condition			Treatment	
	Species	Condition at Time of Attack	Kind of Exposure	
			Bite*	Non-Bite**
Wild	Skunk	Regard as Rabid	S + V ¹	S + V ¹
	Fox			
	Raccoon			
	Bat			
Domestic	Dog	Healthy	No Treatment ² S + V	No Treatment ² V ³
	Cat	Escaped (unknown)		
		Rabid		

*Bite wounds: any penetration of the skin by teeth.

**Non-bite wounds: scratches, abrasions, or open wounds.

V Rabies Vaccine

S Antirabies Serum

¹ Discontinue vaccine if fluorescent antibody (FA) tests of animal killed at time of attack are negative

² Begin S + V at first sign of rabies in biting dog or cat during holding period (10 days)

³ 14 Doses of DEV

species not ordinarily thought to have rabies⁴. One should remember that bites of rats, mice, chipmunks, or rabbits almost never require rabies prophylaxis.²

An apparently healthy animal may be rabid; therefore, if a vaccinated domestic animal bites a person it should be confined and observed by a veterinarian for 10 days. If it becomes ill, the animal should be killed and the head shipped to an appropriate laboratory for examination. An unvaccinated domestic animal that bites a person should be killed immediately and the head examined. Early signs of rabies in wild animals can not be interpreted reliably, so any wild animal that bites or scratches a person should be captured, killed, and examined. If examination of the brain by fluorescent antibody technique in a competent laboratory, e.g., Illinois State Laboratory, is negative, the bitten person does not require treatment.²

If a domestic animal has been properly vaccinated, the likelihood of its developing rabies and transmitting the virus is very small. The circumstances surrounding the bite are important in the physician's assessment. Specifically, an unprovoked attack is more likely to occur with rabid animals. Bites that occur to a person

attempting to feed or handle an animal should usually be considered provoked bites.

The physical examination is critical in determining the type of exposure. The Public Health Service recognizes bite and non-bite wounds categories of exposure (Table). In the past, it has been taught that animal bites from rabid or potentially rabid animals ought not to be sutured. This is not correct. Once appropriate therapy with antiserum and vaccine has been instituted, animal bites should be treated as any other wound and should definitely be sutured if the physician believes suturing is indicated.

If the physician believes that antirabies treatment is indicated, he should first begin local therapy. This consists of a thorough flushing and cleansing of the wound. He may use a quaternary ammonium compound, such as Zephiran, which is viricidal; however, if he does, he must first remove all traces of soap since soap neutralizes the activity of quaternary ammonium compounds. Tetanus prophylaxis and measures to control bacterial infection should be applied at this time, if indicated.

The physician must now decide if he will use passive and active immunization or active

immunization alone, as outlined in Table. In general, the Public Health Service believes that adequate postexposure prophylaxis for bite exposures requires both active and passive immunization. The only currently available immune serum is of equine origin. Consequently, the patient should be closely questioned about allergy to horses and equine products and be given a scratch test before being given serum. The recommended dose of equine serum is 20 IU/lb, 40 IU/kg or 1 vial/55 lb.² If possible, up to 50% of the dose should be infiltrated around the site of the bite and the rest given intramuscularly. Equine serum is not without its complications; indeed, in one reported series, 46.3% of persons over the age of 15 who received serum developed serum sickness. The overall incidence was 16%.⁵ In spite of the reactions to equine serum, it cannot be emphasized too strongly that good, appropriate post-exposure therapy *requires* that serum and vaccine be used. Vaccine alone is not sufficient to protect your patients from acquiring rabies. A new human rabies immune globulin should soon be licensed, and this will eliminate the possibility of serum sickness and should result in wider utilization of globulin in post-exposure prophylaxis.

The only currently available vaccine in the United States is a duck embryo vaccine (DEV) prepared from embryonated duck eggs infected with a fixed virus and inactivated with beta-propiolactone. The older nervous tissue vaccines (Semple type) which caused neuromuscular reactions are no longer available in this country. DEV when given with serum (as it should be in almost all cases) is given in 23 doses. These doses may be given initially as 21 daily injections or as 2 doses daily for 7 days followed by 7 doses in 7 days. Because antiserum suppresses natural antibody formation, booster doses must be given on the 10th and 20th day after completion of the original series. DEV must be given subcutaneously, the most available sites being the abdomen, back, or lateral aspect of the thighs². Local reactions consisting of erythema, pain, tenderness, and pruritus occur almost uniformly and are *not* indications for discontinuing therapy. These problems, while discomforting to the patient and disconcerting to the physician, are consequences of therapy and do not endanger the patient. They can frequently be ameliorated by the use of antihistamines,

such as diphenhydramine hydrochloride. Steroids should not be used unless a life-threatening reaction, such as a neuromuscular reaction, occurs. Corticosteroids delay the development of natural antibodies and may enhance the spread of virus.

In some physicians' practices there will be patients who regularly handle animals, whose vocation or avocation places them at high risk of exposure to rabid or potentially rabid animals. These patients should be considered for *pre-exposure* rabies prophylaxis. Immunization by one of two inoculation schedules² has been shown to be 80%-90% effective in eliciting an antibody response.⁶ All persons who undergo pre-exposure prophylaxis should have their serum tested for rabies neutralizing antibody titers one month after the last dose in the series. They should receive booster doses every 2-3 years. When a person with a previously demonstrable antibody titer is bitten by a rabid or potentially rabid animal, the Public Health Service recommends that he receive 5 daily doses of vaccine plus a booster 20 days later. If a person has had previous pre-exposure prophylaxis but never developed antibody or was never tested for the presence of antibody, he must receive the complete antirabies treatment.

Ultimately, the final decision as to whether or not to treat and the method of treatment to be employed must be made by the primary physician caring for the patient. Local and state health departments can provide vital information to help him reach his decision and should be consulted if the physician has any questions concerning rabies. ◀

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Studies of Histoplasmosis in Two Illinois Communities

BY WALTER F. BUELL, M.D., FRED E. TOSH, M.D., M.P.H., RUSSELL J. MARTIN,
D.V.M., M.P.H., PAUL R. SCHNURRENBERGER, D.V.M., M.P.H., AND
NORMAN J. ROSE, M.D., M.P.H.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH/SPRINGFIELD

Two community-wide investigations of histoplasmosis were conducted in Central Illinois. In one, a diagnosed case led to rumors that a focus of infection in a small town had caused an outbreak. Skin tests of 546 persons in the area revealed 165 (30.2%) reactors but no point source of infection.

Citizens of the other community were concerned over a wooded area used as a starling roost. *Histoplasma capsulatum* was isolated from 10 of 44 soil samples, all from the portion of the woods frequented by starlings. Skin tests conducted on 3750 school children revealed 633 (16.9%) reactors. Grouping results by either school or residence revealed a markedly higher prevalence of histoplasmin reactors near the contaminated woods.

Both investigations revealed that increased prevalence was associated with males, increased age, farm residence, years lived at residence and play areas in woods, bird roosts or old buildings.

WALTER F. BUELL, M.D., San Antonio, Tex. was assigned for this study from the Center for Disease Control, Atlanta, Ga., to the Illinois Department of Public Health, Springfield. FRED E. TOSH, M.D., M.P.H., is Deputy Director, Ecological Investigation Program, Center for Disease Control, Kansas City. RUSSELL J. MARTIN, D.V.M., M.P.H., is the Chief Public Health Veterinarian, Division of Disease Control, Illinois Department of Public Health. Dr. Martin also is an Assistant Professor of Veterinary Public Health at the University of Illinois, Urbana. PAUL R. SCHNURRENBERGER, D.V.M., M.P.H., served as Chief Public Health Veterinarian, Division of Disease Control, IDPH. Last summer he assumed the academic status of Professor of Public Health, Auburn University, Auburn, Ala. NORMAN J. ROSE, M.D., M.P.H., retired in 1971 as Chief of the Division of Disease Control, IDPH. Dr. Rose is a graduate of Northwestern University Medical School.

THERE IS NO evidence to suggest that changes have occurred in the pathogenesis of histoplasmosis, but recently there has been a major shift in our concept of the disease. Between 1906, the year of its first recognition, and 1945, histoplasmosis was regarded as a rare, usually fatal disease. However, the widespread prevalence of histoplasmosis became apparent soon after the histoplasmin skin test came into use in 1945. This brought the realization that the usual infection is benign and self-limited.

Epidemiologic studies have demonstrated point-source outbreaks in many situations, with the organism multiplying in circumscribed areas of soil heavily exposed to bird droppings. In these areas, the problem has been approached with a method of soil decontamination using formaldehyde solution to destroy the fungus.^{1,2} On the other hand, histoplasmosis is endemic in a large part of the country where over half of the adult population is sensitive to histoplasmin but relatively few clearly identified foci of infection have emerged. There is an obvious distinction between endemic and epidemic histoplasmosis insofar as community action is concerned.

In areas where a clearly-delineated area of contaminated soil has resulted in a documented epidemic, there is little doubt as to the community's need. The course of action is less clear when a community has a suspected area of contaminated soil without apparent clinical disease in its inhabitants.

This study reveals investigations into 1) an "outbreak" in a community, and 2) a commu-

nity with a large starling roost.

Community Background

CHAMPAIGN COUNTY—Histoplasmosis was suspected in a 6-year-old boy from Thomasboro, a town of 458 residents. Rumor developed that a chicken coop in town was the source of a major outbreak. Physicians in the community requested the Illinois Department of Public Health to investigate the situation.

SPRINGFIELD—Residents were concerned over the presence of a large starling roost just outside the city limits. This roost was in a 35 acre privately owned woodlot bordered on the south by a street which was scheduled for widening, and on the east by a mobile home court. The lot also was used as a play area by neighborhood children. There was concern that it might be a focus of infection and the Illinois Department of Public Health was requested to investigate.

Materials and Methods

CHAMPAIGN COUNTY—Community-wide testing was conducted with a commercial histoplasmin in September, 1967. The main focal point was Thomasboro with Rantoul High School students selected as controls.

SPRINGFIELD—Soil samples of approximately one pound each were collected from the starling roost in Springfield and tested for the presence of *Histoplasma capsulatum* by the Illinois Department of Public Health (six samples) or Center for Disease Control (44 samples).

Skin testing was done with histoplasmin HKC-5 (Kansas City) in Springfield. Eight schools were selected for testing in May, 1968. Five schools were near the bird roost while three were across the city from the roost. The antigens were injected intradermally in the forearm in 0.1 ml. amounts.

Sterile disposable needles and syringes were used in Champaign County and jet injector guns in Springfield. The site of inoculation was examined after 48 hours and areas of induration 5 mm. or more in diameter were considered positive tests.

Questionnaires completed prior to inoculation included: present address, years at address, age, sex, school, play area (old buildings, woods, bird roost), and farm contact (ever lived on farm, visits to farms twice a week, weekly, monthly, twice a year, or a week at a time). Age adjusting was performed for both surveys using the total population tested as the standard.

Results

CHAMPAIGN COUNTY:

Spot mapping the test results by residence revealed no grouping of reactives within Thomasboro or other areas of Champaign County. There were 546 persons tested with 165 reactive (30%). The 36.8% (74/201) reactors in Thomasboro was much higher than the 9.7% (15/154) in Rantoul but slightly lower than the 39.8% (76/191) from other communities in the vicinity. The age adjusted prevalence for the three groups was 43.8%, 11.1% and 43.8%, respectively. There was an increase with age in each community tested (Table 1).

The age adjusted prevalence did not increase with the length of residence at present address. However, persons with four or more previous places of residence had a prevalence of 19.6% (18/92) reactors compared with 25.0% (37/148) among those with 2-3 previous residences and 35.9% (110/306) in those with none or only one. The age adjusted prevalence for these three groups was 19.9%, 20.3% and 31.4% respectively. This latter rate (31.4%) differs significantly from the first two prevalences at the 1%

Table 1. Age Distribution of Champaign County Residents Tested with Histoplasmin

Age	Thomasboro		Rantoul		All Others		Total	
0-4	0/15	—	0/3	—	3/14	21.4%	3/32	9.4%
5-9	3/36	8.3%	0/10	—	7/46	15.2%	10/92	10.9%
10-14	12/44	27.3%	10/91	10.9%	17/54	31.5%	39/189	20.6%
15-19	4/11	36.4%	4/40	10.0%	8/15	53.3%	16/66	24.2%
20-29	7/19	36.8%	0/1	—	10/13	76.9%	17/33	51.5%
30-39	18/25	72.0%	0/1	—	18/23	78.3%	36/49	73.5%
40 +	28/47	59.6%	1/1	100.0%	11/17	64.7%	40/65	61.5%
Unknown	2/4	50.0%	0/7	—	2/9	22.2%	4/25	20.0%
Total	74/201	36.8%	15/154	9.7%	76/191	39.8%	165/546	30.2%

Numerator = No. Reactive
Denominator = No. Tested

Table 2. Relationship Between Histoplasmin Reactivity and Degree of Farm Contact in Two Illinois Communities

Farm Contact	Champaign County			Springfield			Total
Once resided	104/254	40.9%	(35.2)	91/241	37.8%	(28.8)	195/495 39.4%
Visits of week duration	5/12	41.7%	(21.1)	15/47	31.9%	(14.7)	20/59 33.9%
Twice a week visits	2/8	25.0%	(3.6)	14/87	16.1%	(13.9)	16/95 16.8%
Weekly visits	8/32	25.0%	(17.1)	21/115	18.5%	(18.5)	29/147 19.7%
Monthly visits	11/39	28.2%	(21.3)	46/310	14.8%	(16.0)	57/349 16.3%
Once or twice a year	23/136	16.9%	(18.5)	194/1253	15.5%	(15.2)	217/1389 15.6%
Never visit	12/65	18.5%	(20.3)	210/1455	14.4%	(15.1)	222/1520 14.6%
Not stated	—	—	—	42/242	17.4%	(16.5)	42/242 17.4%
Total	165/546	30.2%		633/3750	16.9%		798/4296 18.6%

Numerator = No. Reactive

Denominator = No. Tested

() = age adjusted percent reactive

level.

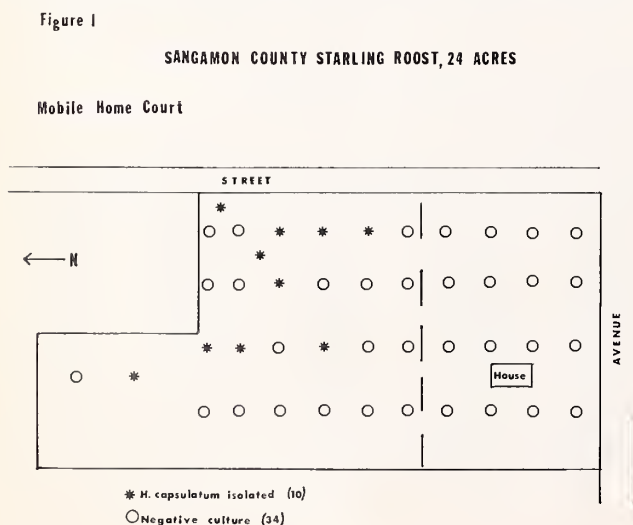
The 32.2% (77/239) reactors in males was slightly higher than the 28.7% (68/307) in females. This difference was increased to 33.8% versus 26.6% when the data were age adjusted.

There was a correlation between reactivity and previous farm residence but not with amount of farm contact in non-farm residents (Table 2).

Responses to the question on play area were infrequent but there was a higher prevalence among those who played in old buildings (28%, 11/40), than in wooded areas (8%, 1/13), or bird roosts (13%, 4/32).

SPRINGFIELD:

Six soil samples were collected from the starling roost in November, 1965. They were combined into two pools of three samples each. *H. capsulatum* was isolated from one of the two pools. The area was visited in June, 1967 to collect soil samples from 44 equally spaced locations (Figure 1). Ten of the 44 samples contained *H. capsulatum*. All positive samples were from the northeast portion of the woods, the part

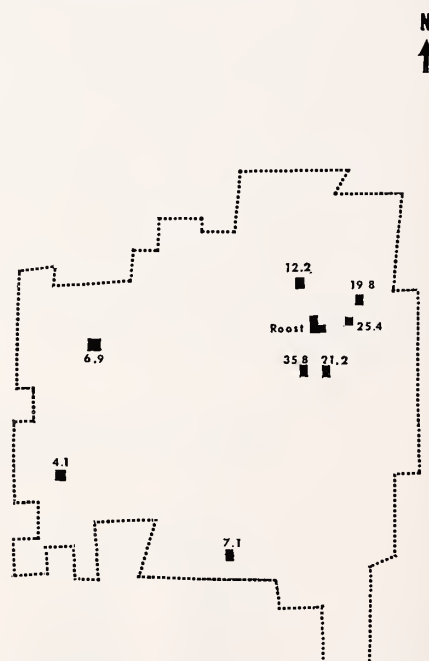


utilized as a starling roost.

There was a definite correlation between histoplasmin reactivity and proximity of residence to the woods, but the number of years at present address did not seem to be related. This geographic importance was also illustrated by the age adjusted prevalence in various schools. (Figure 2). Histoplasmin prevalence was much high-

Figure 2

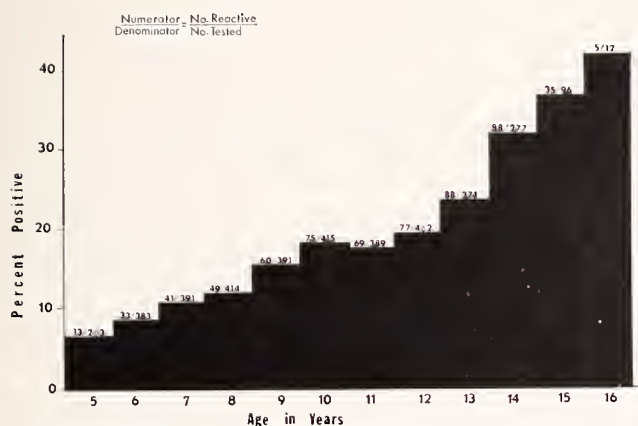
AGE ADJUSTED HISTOPLASMIN SKIN TESTING REACTOR RATES, Springfield, Illinois Schools, 1968



er in the schools near the roost. In the case of both residence and school, higher prevalence was found southeast (downwind) from the woods.

The reactor rate increased with age except for the 11-year-olds (Figure 3).

Figure 3. Histoplasmin Reactivity of Various Age Groups Tested in Springfield, 1968



The 17.8% (326/1829) among males was not among females. Age adjusting did not change these rates. The prevalence in males (46/775) in the three schools furthest from the roost did not vary significantly from the rate in females (48/809) in the same schools. Likewise, the prevalence in males (280/1046) in the five schools close to the roost did not differ significantly from the rate in females (253/1073) in these schools.

Of children who played in old buildings, 23.9% (112/469) were positive. This is higher than the 17.8% (182/1022) among those who played in woods or near bird roosts and the 15.2% (339/2259) among the children who denied playing in any of these areas. Age adjusting changed the figures to 22.6%, 18.0% and 15.3% respectively.

There was a correlation between prevalence and prior farm residence but not for frequency of farm visits among non-farm residents (Table 2).

Discussion

Although Thomasboro had a higher age-adjusted prevalence than Rantoul, it was similar to that of the small neighboring communities. In view of this similarity with neighboring towns and the lack of clustering of reactors within the town, the fears of the townspeople could be allayed that no specific focus of infection could be found.

In Springfield, the soil sampling results suggested the south portion of the woods, which had not been used as a bird roost, was *not* contaminated with *H. capsulatum*. Therefore, no problem should be encountered felling trees and bulldozing to widen the road so long as these operations were confined to the south portion of the woods.

However, the higher prevalence of skin test positivity to histoplasmin found in schools and

in residences near the roost provided strong circumstantial evidence that the woods represented a focus of infection for the community. Although a potentially important source had been discovered and a method for decontaminating such foci has been described,² the problem still was not resolved.

The starling flock represents the primary problem, but there is no easy solution for long-term removal of such a roost other than felling the trees. Soil decontamination by formaldehyde is difficult but possible. The cost, logistics, and labor involved would be considerable. In addition, decontamination without dispersal of the birds would be less than ideal since the birds would continue to provide nutrients in their droppings and the area could become recontaminated through airborne transfer of spores. Finally, unless cases of histoplasmosis could be detected, retrospectively, among children near the woods out of proportion to children living more distant, there might be a question as to the present danger to health of the community. Imminent need to clear the woods, as for subdivision, would clearly necessitate more urgent action. Obviously, many variables are involved when decontamination procedures are considered and different roosts must be evaluated individually.

The presence of two schools within three miles of each other but with age-adjusted histoplasmin reactivity of 4.8% and 35.8% demonstrates the fallacy of transposing prevalence data from one situation to another. The situations may not be as similar as they seem.

The increased prevalence in males over females is small but it was present in each area tested here and in other studies.³ In view of the ages tested, this difference would not appear to be occupational. Differential susceptibility does not seem likely, so either play habits or play areas would appear to be the most probable factors.

The low prevalence in Rantoul compared with the smaller towns to its south, could represent poor sampling, gross geographic difference or urban-rural difference. The large number of Air Force families in this area could introduce unknown factors but the importance of farm residence in these as well as other investigations,^{3,4} suggests that urban-rural residence is the major factor.

These investigations go beyond solving two community problems. Other workers have pointed out the presence of large⁵⁻⁷ and small⁸ foci

(Continued on page 73)

Accidental Ingestion

Methadone, Propoxyphene (Darvon), or Diphenoxylate (Lomotil) Poisoning

BY RUTH ANDREA SEELER, M.D.

PEDIATRIC HEMATOLOGIST, COOK COUNTY HOSPITAL & HEKTOEN INSTITUTE/CHICAGO

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. Initially, the series will be based on patients seen by the author at the Cook County Hospital, Division of Pediatrics. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed. This series will alternate with the maternal death studies.

Column A lists three compounds whose accidental ingestion by children is occurring with alarming frequency. For each item in Column A select the appropriate statements from Column B.

A

Methadone
Propoxyphene-Darvon®
Diphenoxylate & Atropine-Lomotil®

B

1. Is or contains a narcotic derivative.
2. Overdose produces deep coma.
3. The clinical picture worsens rapidly.
4. Constricted pupils are a common finding.
5. Respiratory depression—arrest.
6. Naloxane (Narcan®) is a specific antagonist.
7. Not very toxic.

(Answers follow in discussion)

Although "prevention is the best cure" for the problem of accidental poisoning in children, that utopia is not on the horizon. In spite of increasing public awareness of the problem, remarkably little has been accomplished in the area of prevention. Therefore, physicians will continue to be confronted by children having ingested a variety of medications.

The reasons for failure of prevention are numerous. Many children get into the pills in the handbag of an aunt, grandmother, baby

sitter, etc. Because of the tendency of many individuals to put all of their pills into one bottle, toddlers have died after sampling grandmother's digitalis, KCI, diuretics, and anti-hypertensives; all conveniently packaged in one bottle. The bottle is frequently kept in a handbag or left on the bedside table. Physicians treating the "grandparent" age group should stress the extreme dangers to little children and point out the ease with which curious toddlers get into pills.

Pill bottles with the "pressure and turn" tops are excellent deterrents to children. However, adults have found these types of closures sufficiently difficult to open that frequently the bottle has been left totally uncapped! This, of course, is totally self-defeating.

Particularly dangerous are the relatively "non-toxic drugs" which are commonly dispensed in large (potentially fatal) quantities. Examples include aspirin and ferrous sulfate. An appropriate alternate would be cellophane encasement of individual tablets. Children ingest drugs when they are unsupervised and the individual cellophane packaging of pills would take advantage of the relatively short attention span of children. After working to get the first few tablets they would probably get bored and abandon the project. If they didn't, it will still take them a significantly longer period of time to open and ingest a toxic dose. Hopefully, they would not be unsupervised for such a long period.

Parents should be instructed not to try to teach children "that medications are candy." Children learn by imitation; thus, parents should be reminded not to take pills in front of children. That only encourages the children to copy their parents. An event which may prove fatal.

Particularly frustrating is the fact that for most ingestions there is no specific therapy or antidote. Therapy is symptomatic and directed toward maintaining respirations until the patient metabolizes or excretes the drug.

Discussion

If you answered numbers 1-6 for each of the items in Column A score yourself a 100%. All of the drugs are narcotic derivatives or analogues and therefore overdose produces all the symptoms of morphine and heroin overdose.

Methadone is the prototype for such toxicity. The symptoms began as somnolence, followed by shallow respirations in a patient with constricted pupils. There follows a very rapid progression to a comatose, hypotonic state with profound respiratory depression and finally respiratory arrest.¹⁻³ Pulmonary edema may further complicate the clinical situation, presumably due to an inappropriate ADH secretion¹.

Because of the narcotic effect on the gastrointestinal tract the medication may remain in the stomach for a protracted period. Therefore, gastric lavage should be done even if the patient is seen quite late after the overdose.

Relatively small quantities of methadone (10-

20mg) can cause quite severe respiratory depression in children and the dose of methadone used for heroin maintenance is larger than this. Therefore, any child who accidentally ingests either the liquid form in orange juice or the tablets, should be watched closely and treated vigorously should respirations become shallow.

Propoxyphene hydrochloride or napsylate-Darvon® is potentially a very toxic compound.⁴⁻⁶ As little as 160mg of propoxyphene has produced profound unresponsiveness and coma in a three-year-old child.⁶ This would be equivalent to three of the Darvon 65 tablets or combinations or three of the 100 mg napsylate salt. Propoxyphene combined with aspirin produces a doubly deadly hazard due to the additional aspirin toxicity⁴. Following the ingestion of toxic amounts, convulsions, apnea, and cyanosis may begin within 20-30 minutes. The respirations may become quite shallow and respiratory arrest may follow.

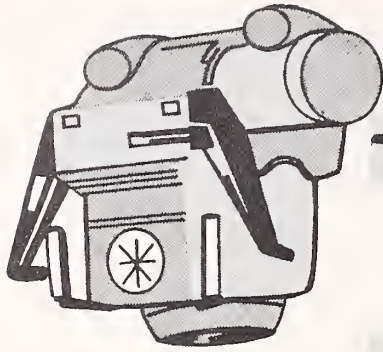
Lomotil® is a combination of diphenoxylate hydrochloride (a narcotic) and atropine sulfate. The atropine is included in the preparation to prevent it from being an addicting drug.

The drug is currently considered contraindicated in children under two years of age⁷. Cardiac arrest has followed the ingestion of only six tablets by a two year old child⁸. The initial symptoms are those due to atropine, namely temperature elevation, tachypnea, and a generalized flush. After 2-3 hours, the onset of narcotic phase begins with central nervous depression, pinpoint pupils, shallow respirations progressing to a respiratory arrest.⁷⁻¹⁰

Therapy

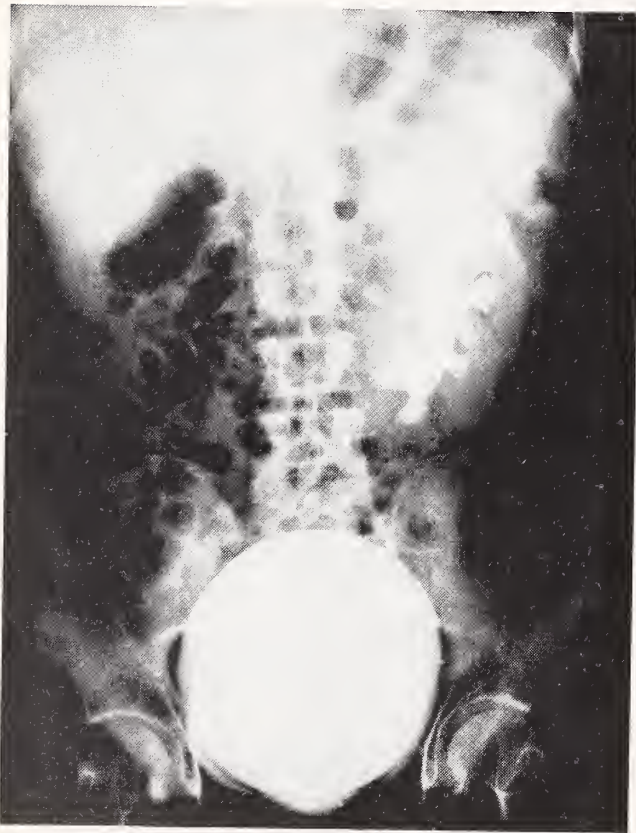
Therapy for an overdose of these three drugs is dramatic and gratifying.¹⁻¹⁰ Even in children with a respiratory arrest, prompt treatment by the narcotic antagonist naloxone (Narcan®) produces dramatic results.³ The patient responds dramatically in a matter of minutes with the establishment of respirations, dilation of the pupils, and they may even begin to speak. However, the duration of the naloxone effect is short (two hours) when compared to the narcotic depression. Therefore, frequently it is necessary to administer repeated doses of naloxone should central nervous system or respiratory depression recur. Patients must be observed in the hospital for this possibility. It is not safe to treat the child with a history of ingestion of either propoxyphene, methadone, or diphenoxylate by simply giving him naloxone on an outpatient

(Continued on page 73)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 35-year-old female entered the hospital for evaluation of mild hematuria. An IVP was done.

What's your diagnosis?

1. Horse-shoe kidney.
2. Congenital solitary kidney.
3. Non-functioning half of a horse-shoe kidney.

(Answer on page 74)

Womanpower in Radiology

Let me hasten to assure that (manpower in radiology) . . . includes WOMANPOWER! Statistics about radiologists in training programs indicate that we will soon have an abundance of new talent in the field of radiology. Those of us who seek new associates will welcome this news. It remains to be seen whether these new radiologists filter down to the smaller communities. If they collect in already over-crowded urban locations, we may well have again the intense competition between "incumbent" hospital radio-

logists and eager younger men who are willing to displace them if the administrator can negotiate such a change. It seems appropriate to reiterate the practical point that radiologists who do a good professional job and provide appropriate service for physicians and patients in a hospital are in a strong position on the medical staff. (Seymour Fiske Ochsner: "Thoughts and after thoughts." *Practical Radiology* (Apr) 1973, pg. 14).

Nonketotic Hyperglycemic Coma in Infancy

BY RONALD D. GREENWOOD, M.D., HOWARD S. TRAISMAN, M.D.,
MATTHEW M. STEINER, M.D., AND SIRUS A. HADAWI, M.D./CHICAGO

Hyperglycemia in infancy is uncommon. When it occurs, prompt discovery of its etiology is crucial. True diabetes mellitus occurring in this age group is very rare,¹ and numerous other etiologies must be considered.

We have seen a series of infants who presented in coma with hyperglycemia without acetonuria. They were diagnosed and treated as diabetics. Their symptomatology was similar to nonketotic hyperosmolar coma which is usually seen in late adult life.

This article reviews the causes for hyperglycemia, presents patients exemplifying these etiologies and notes the difficulty of differential diagnosis of hyperglycemia in infancy.



Taisman

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An infant who exhibits hyperglycemia is often a diagnostic challenge to the pediatrician. However, the patient is frequently diagnosed as having true or transient diabetes mellitus without further consideration.

During the last 15-year period at Children's Memorial Hospital, there have been nine instances of infants who were incorrectly diagnosed as having diabetic acidosis. All of these patients were seriously ill with coma. The nine patients are described in Tables I, II and III. They ranged in age from two weeks to 14 months. None had a family history of diabetes. Their sugars ranged from 206 to 880 mg%. All had glucosuria without acetonuria, and most were acidotic. Six infants were treated with insulin and all but one died shortly after admission.

A brief clinical summary of one of these infants is presented as a typical example. Patient 6 was an 11-month old white male with a 1½ week history of a cold which was improving when three days before admission he experienced fever, diarrhea and vomiting. His stools were watery and numbered 4 to 18 per day; kapectate and tetracycline had been administered. He became lethargic and was brought to this hospital.

On initial evaluation, he was found to be comatose and while being examined he stopped breathing. He was resuscitated and was given oxygen and plasma. His temperature was 102°F (R) (38.9°C), heart rate 200/min. with rapid respirations and a weight of 22 lb. 8 oz. (10.2kg.). The infant was markedly dehydrated with poor skin turgor and sunken fontanelle and eyes. He remained comatose. Reflexes were hypoactive but equal, and the remainder of the examination was not unusual.

Initial laboratory investigations revealed the blood glucose 482 mg%, blood urea nitrogen 27 mg%, serum sodium 150 mEq/L, serum po-

tassium 4.7 mEq/L, serum CO₂ 9.2 mEq/L, serum Cl 106 mEq/L and blood pH 7.38. Urine clinitest was 4+ while both urine and serum acetone were negative.

After administration of plasma, the blood glucose was 880 mg%. Regular insulin 2u/kg (10 u. subcutaneously, 10 u. intravenously) was given. The patient remained in critical condition and 2½ hours after admission had a cardiac arrest and expired.

Cultures of stool, blood, throat, and urine obtained pre-mortem were negative.

Autopsy revealed a post mortem blood culture of *Staphylococcus aureus* coagulase positive, diffuse fatty metamorphosis of the liver, pulmonary edema, lymphoid hypelasia of the small and large bowel, adrenal hypoplasia and cerebral edema with focal subarachnoid cerebeller hemorrhage. Sections of the pancreas stained with hematoxalin and eosin revealed a normal acinar pattern with an abundance of cellular islets of Langerhans and moderate congestion. A Heidenhain's stain for beta cells revealed sufficient beta granules in the islets.

Discussion

Infants with severe diabetic ketoacidosis present with coma, vomiting, dehydration and evidence of infection. Hyperglycemia, glucosuria, and acetonuria are usually present.² Occasionally they may not demonstrate acetonuria in early infancy.³

However, one must consider other causes of hyperglycemia. These causes are noted in Tables IV²⁻²⁵ and V.^{5,26-42} The greatest difficulty in differential diagnosis is the infant with shock, dehydration, hyperglycemia and acidosis from non-diabetic causes.

Hyperglycemia in severe dehydration with hypernatremia due to severe gastroenteritis,^{14,43-45} feeding error⁴⁶ or experimental induction,^{47,48} has been noted. We feel some of our patients fall into this category (patients 1, 6, and 7 in Table 1). Both hypertonicity^{47,48} and stress¹⁴ are postulated mechanisms. Hypernatremia may occur in diabetes in children with hyperosmolar nonketotic diabetic coma,⁴⁹ but rarely in transient neonatal diabetes mellitus.³ None of the patients in Table I meet the strict criteria for hyperglycemic hyperosmolar nonketotic come,⁵⁰ although the osmolality in a few patients would meet the criteria established by Rubin et al.⁵¹

Shock has also been noted to produce hyperglycemia,⁷ as has dehydration with metabolic acidosis from non-diabetic causes.¹⁵ Epinephrine

Table 1. Clinical Description of Infants

Patient	Age	Sex	Symptoms* Findings
1	14 mos.	F	C,D,Cy,F
2	2 wks.	M	C,D,Cy,DI
3	10 mos.	M	C,S,F,R
4	5½ mos.	M	C,D,F
5	4½ mos.	M	(DOA),C
6	11 mos.	M	V,DI,F,C,D arrested
7	11 mos.	M	V,DI,F,C,D,Cy
8	7 mos.	F	C,S,D
9	4 mos.	M	C,S,F

*Symbols:
C—Coma
D—Dehydrated
F—Fever
S—Seizure
(DOA)—Dead on arrival
DI—Diarrhea
V—Vomiting
Cy—Cyanosis
R—Rales

has been shown to be the mediator in the former^{7,52} while insulin resistance has been observed in the latter.¹⁵ Some of our patients (patients 1, 2, 4, 5, 6, 7 in Table 1) fall into this category of shock-related hyperglycemia. Central nervous system disease with seizures producing hyperglycemia is also considered²⁰ (patients 3, 8 and 9 in Table 1 comprise this group).

The diagnostic difficulty presenting the physician with an infant with hyperglycemia and coma is considerable. A history of previously diagnosed diabetes now out of control, drug ingestion, glucose of high osmolar solution ingestion, and seizures, or physical findings of endocrine disease known to cause hyperglycemia are most helpful in establishing a correct diagnosis. Shock and dehydration must be evaluated by estimation of severity of any diarrhea by his-

Table 2. Laboratory Evaluation of Infants

	Somogyi, mg % Admission Blood Glucose	Urine Clinitest/ Acetest	Admission CO ₂ (mEq/L)	Admission Na (mEq/L)	Admission BUN (mg %) (NPN)	Calc. Osmolal.
1	532	4/0	8.6	153	(111)	336
2	206	3/0	7.0	143	(123)	298
3	315	4/0	17.7	142	(24)	301
4	135*	4/0	27	146	—	299
5	320**	4/0	4.2	136	88	290
6	482***	4/0	9.2	150	27	327
7	600	4/0	2.9	150	160	333
8	600	4/0	9.6	144	160	321
9	454	4/0	—	133	22	292

*—Previous 380; **—Rose to 714
***—Rose to 880

Table 3. Treatment and Outcome

Treatment*		Outcome*	Autopsy	Autopsy Pancreas	Hyperglycemia Diagnosis
1	F	D 45 min. after adm.	None	—	Shock, hypernatremia
2	F,A,I,S	D 24 h. after adm.	None	—	Shock, acidosis
3	F,A,I	D 10 h. after adm.	Hemorrhagic pneumonitis	N	Seizure
4	F,A (prev. 1)	D 5 h. after adm. Glucose ▼ to 9	Pneumonitis, Brain edema Marked LVH	N	Dehydration, shock
5	F,A,I,R	D 24 h. after adm.	Coroner's Case	N	Shock, clin. cer. hemorrhage
6	F,I,R	D 2½ h. after adm.	Staph, sepsis, Pulmonary edema, Cerebral edema, Fatty liver	N	Shock, hypernatremia
7	F,A	D 2 h. after adm.	Pneumonitis, Bilateral toxic nephrosis 2° infect. or shock	N	Shock, hypernatremia
8	F,A,C	D 5 h. after adm.	Bilat. hypoplastic kidney with chronic inflam; Parathyroid hyperplasia; Renal osteodystrophy	N	Seizure
9	C,A,I	age 11 mos. doing well	—	—	Seizure

*Symbols:

F—Fluids
S—Steroids
R—Resuscitation
D—Died
N—Normal by light microscopy

A—Antibiotics
I—Insulin
C—Anticonvulsants

tory, noting presence or absence of acetonuria and hypernatremia. Treatment should be started with isotonic saline.

In both transient and true diabetes mellitus in the neonatal period, there is often no acetonuria^{3,4} while in diabetes occurring later in infancy, acetonuria is more frequent^{17,53-59} as in the typical juvenile diabetic.² This is substantiated by patients in this age group with diabetes that we have seen at this hospital (Table 6).^{4,60} Nonketotic hyperglycemic hyperosmolar coma rarely occurs in children.^{41,61}

Tracing the etiology of hyperglycemia may indeed be difficult. It is possible that some of the reported cases of transient diabetes mellitus of infancy may fall into a category of secondary hyperglycemia.^{3,62}

Suggested Approach

We would suggest the following approach to the hyperglycemic infant based on our series and a review of the literature:

Insulin should be withheld from hyperglycemic infants with dehydration, hypernatremia or shock, and no acetonuria until the dehydra-

Table 4. Disease States Which Might Cause Hyperglycemia

Juvenile diabetes mellitus ²
Transient neonatal diabetes mellitus ³
Permanent neonatal diabetes mellitus ⁴
Hyperpituitarism (pan or partial) ⁵
Hyperthyroidism ⁵
Hyperadrenocorticism ⁶
Pheochromocytoma ⁵
Shock ⁷
Severe burns ^{8,9}
Complication of hemodialysis ¹⁰ or peritoneal dialysis ¹¹
Ingestion of large amount glucose ¹²
Heat stroke ¹³
Dehydration, hypernatremia ¹⁴
Dehydration, acidosis ¹⁵
Agenesis of pancreas ¹⁶
CNS disease (seizure, injury, hydrocephalus, anencephaly, hypothalamic lesions) ^{5,17-20}
Severe infection ^{19,21}
Starvation followed by refeeding ²²
Prolonged starvation ⁵
Liver disease ²³
Glycogen storage disease ⁵
Surgical removal of pancreas ⁵
Pancreatitis ⁵
Hypothermia ²⁴
Cystic fibrosis ²⁵

Table 5. Drugs Which Are Capable of Producing Hyperglycemia

DRUG INGESTED
Nalidixic acid ²⁶
Dilantin ^{27,28}
LSD ²⁹
INH ³⁰
Nicotinic acid ³¹
Oral contraceptives ³²
Epinephrine (and congeners) ³³
Glucagon ³³
Diazoxide ³⁴
Thyroid ³⁵
Androgens ³⁵
Estrogens ³⁵
Corticosteroids ⁵
Indomethacin ³⁶
Thiazides ³³
Caffeine ³⁷
Chlorpromazine ³⁸
Marihuana ³⁹
Ethacrynic acid ⁴⁰
Salicylates ⁴¹
Nicotine ⁴²

tion is corrected, and the patient is out of shock. The blood sugars usually will then rapidly return to normal in nondiabetics.^{7,14,15} After the infant recovers from his acute episode, an oral glucose tolerance test should be performed.²

When the blood glucose does not rapidly drop within a few hours, insulin in very small doses may be given ($\frac{1}{4}$ - $\frac{1}{2}$ u/kg. initially) with more administered as necessary. This is based on the assumption that the patient has diabetes mellitus.

The hyperglycemic infant with acetonuria should be treated initially as having diabetes mellitus because one must act quickly with in-

sulin and fluids to avoid the irreversible cerebral edema due to diabetic ketoacidosis from dehydration, acidosis and aceto-acetate anoxia.⁶³

The neonate with hyperglycemia and without acetonuria may represent transient or permanent neonatal diabetes mellitus and should be a candidate for treatment with insulin in the previously mentioned small dosages.

In order to accurately diagnose these infants, any patient with coma, dehydration or signs of sepsis should have a blood glucose determination in addition to serum electrolytes and cultures.

This syndrome of nonketotic hyperglycemic coma represents a collection of findings, not a disease entity. The causes of this syndrome require vigorous pursuit and treatment.

Summary

A series of infants with non-diabetic nonketotic hyperglycemic coma are reported; the features of this syndrome in these infants included dehydration with hypernatremia, shock, acidosis and central nervous system disease. The causes of hyperglycemia in infancy are numerous; the diagnosis of diabetes mellitus in infancy is difficult and must be made with care. It is hoped that increased awareness of hyperglycemia of non-diabetic etiology will lessen hypoglycemic reactions to inappropriate insulin therapy and provide more accurate diagnoses. ◀

References

A complete bibliography of "Nonketotic Hyperglycemic Coma in Infancy" may be obtained by writing to: *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago 60601.

Table 6. Infants With Diabetes Mellitus

Patient	Age	Sex	Findings	Fam. Hx. Diabetes	Adm. Blood Glucose (Somogyi, mg%)	Urine Clinitest/ Acetest	Treatment	Outcome
1 (60)	6 mos.	F	Cretin on thyroid, vomiting, dehydration	0	1120	4/mod	F,I	D at 10 mos. Pneumonitis, encephalomalacia, cystic pancreas, kidneys, hypoplastic thyroid
2 (4)	60 h.	F	Low birth weight, hyperglycemia	0	60 h-275 88 h-333	3/0	F,I	A at 1½ yrs. doing well on insulin
3 (4)	30 d.	F	Low birth weight, fever, FTT, polyuria	0	880	4/T	I	A at 5½ yrs. doing well on insulin
4	8 d.	M	Low birth weight, hyperglycemia	?	12 d-182 abn. GTT	4/L	I	A at 10 mos. normal GTT
5	11 mos.	F	Fever, polyuria, polydypsia, lethargy, coma	+	700	4/L	I,F	A at 7-7/12 yrs. doing well on insulin
6	10 wks.	M	Seizures, polyuria	0	390	4/S	I	A at 9 mos. on insulin; Hypsarrhythmia

Abbreviations: I—Insulin; F—Fluids; D—Died; A—Alive; GTT—Glucose Tolerance Test.



Ulcer Recurrence After Vagotomy and Pyloroplasty

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 2, 1972.

Dr. Michael Peters: A 53-year-old Negro man was admitted on March 31, 1972, with a 24 hour history of dark "coffee-ground" vomitus and black stools. One month prior to admission the patient had epigastric pain which was relieved by antacids. He did not smoke, was not an alcoholic and denied the ingestion of salicylates.

His past medical history was significant. In 1967, he had upper gastrointestinal bleeding and his hematocrit fell to 20. He was treated with two units of whole blood. In 1969, massive bleeding recurred and an emergency operation was required. Vagotomy, pyloroplasty and oversewing of a duodenal ulcer were performed. He is a mature diabetic, controlled by diet alone.

Physical examination at the time of the present admission revealed a moderately obese Negro man, not in acute distress but with a tachycardia of 130, blood pressure 140/90. Examination was otherwise unremarkable except for guaiac positive black stool in the rectum. Gastroscopy was performed and a one cm prepyloric ulcer was demonstrated on the lesser curvature with a clot on it but which was oozing. Upper gastrointestinal X-rays were also obtained. The next day the aspirate from the nasogastric tube was clear and he was started on oral feed-

ings. One week later, upper gastrointestinal X-rays and gastroscopy were repeated and were reported to be normal. Gastric analysis with Histalog was normal; however, a Hollander test was positive, indicating an incomplete vagotomy.

Dr. Harold Matthies: The upper gastrointestinal studies in 1967 demonstrated an ulcer crater in the duodenal bulb (Figure 1). The films in 1969 do not show a crater although he bled at this time. Now, in March of this year, a lesion was seen on the lesser curvature, (Figure 2) and in review, we think that this is what Dr. Peters referred to. This is not clearly radiographic ulceration; however, he is bleeding.

Dr. John Beal: Dr. Matthies, does the fact that he had a pyloroplasty make it difficult for the radiologist to interpret the films?

Dr. Harold Matthies: Yes - it is often impossible to distinguish between surgical deformity and ulcer deformity.

Dr. Michael Peters: The patient was taken to the operating room and a partial gastrectomy was performed. He was discharged 10 days post-operatively. In summary, the patient presented the problem of recurrent ulceration after vagotomy and pyloroplasty.

Dr. Alex McGinnis: At least four questions



Figure 1. Upper gastrointestinal series showed ulcer crater in the duodenal bulb in 1967.

are raised by this case. First, what is the location of an ulcer when it recurs after vagotomy? Dragstedt recently reviewed his series of vagotomy and pyloroplasty at the University of Florida. Among 416 patients, there were 14 with recurrent ulcer. In 9 of the patients, the recurrent ulcer was located in the duodenum. In two of the patients the recurrent ulcer was located in the stomach. The location of the recurrent ulcer in this case was in the stomach.

A second question is: What is the incidence of ulcer recurrence after vagotomy and pyloroplasty? In Dragstedt's series, 14 recurrences among 416 cases of vagotomy and pyloroplasty was a recurrence incidence of 4%. A VA Co-operative Study reported a recurrence incidence of 9% among 337 patients upon whom vagotomy and drainage had been performed. Farris reports a 1% recurrence rate. Other recurrence rates are as high as 25%.

A third question is: What is the etiology of ulcer recurrence after vagotomy and pyloroplasty? There are at least three possible factors. The first is incomplete vagotomy. Completeness of vagotomy is determined by the Hollander test. The second possible cause is pyloroplasty failure. A pyloroplasty is said to fail when there is delayed gastric emptying. With delayed gastric emptying, there is stasis of food and gastric juice in the antrum of the stomach which in turn stimulates the antral phase of gastric secretion and there is hypersecretion on a stasis basis.

The third possible cause is a gastrin-proceeding Zollinger-Ellison tumor which will cause ulcer recurrence after any type of ulcer operation, short of total gastrectomy. Dragstedt advises that when peptic ulcer recurs as a duodenal ulcer, the cause is incomplete vagotomy, but when it recurs as a gastric ulcer, the cause is pyloroplasty failure. Among Dragstedt's 14 recurrences, the precise etiology of the recurrence could not always be determined. In most, the recurrence was thought to be the result of incomplete vagotomy. In 4 of the 14 recurrences, there was delayed gastric emptying on X-ray. In these 4 patients, the etiology of the recurrent ulcer was considered to be failure of the pyloroplasty. There were no Zollinger-Ellison tumors among his recurrences. In this patient, the Hollander test showed incomplete vagotomy. A follow-up film after the upper gastrointestinal X-ray examination was not obtained. Such a film would have shown whether or not there was impaired gastric emptying. The gastric analysis ruled out the presence of a Zollinger-Ellison tumor. In addition, the ulcer recurred as a gastric ulcer, suggesting that the cause was inadequate gastric emptying or so-called pyloroplasty failure. This patient's recurrent ulcer could have had as an etiology, both incomplete vagotomy and pyloroplasty failure.

The fourth question is: What is the proper treatment of ulcer recurrence after vagotomy and pyloroplasty? If one could somehow know for sure that an ulcer recurrence was due to incomplete vagotomy, or somehow know that it was due to pyloroplasty failure, then surgical

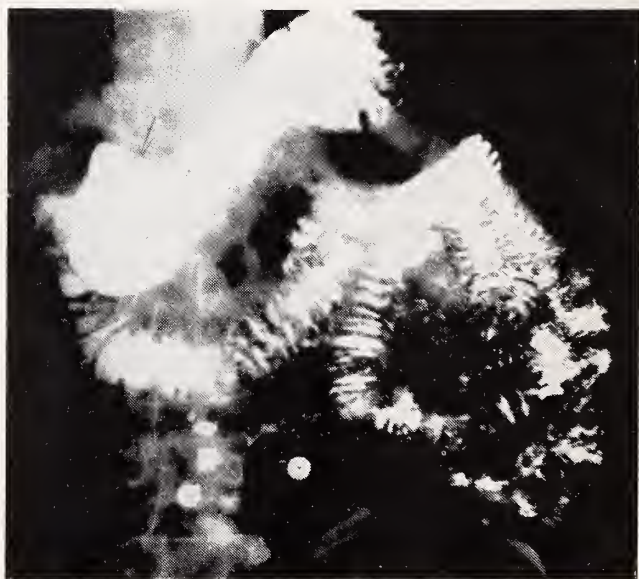


Figure 2. Arrow indicates defect along lesser curvature of stomach which was thought to be site of ulceration in 1972.

therapy could be very precise. Those patients with incomplete vagotomy would be treated by simply completing the vagotomy. This could be done either transabdominally through the old operative area or could be done using transthoracic approach. Those patients with ulcer recurrence due to pyloroplasty failure could be treated by providing an adequate gastric emptying procedure. Efforts to be this precise in surgical therapy have been made and have only produced a high incidence of further recurrent disease. Best results are obtained by performance of a subtotal gastric resection.

There is theoretical basis for why a subtotal gastric resection could be very effective for this patient. A subtotal gastric resection completes the vagotomy because a large portion of the parietal cell mass is resected, and secondly, any gastric emptying problems are solved through the creation of a wide open Billroth II gastrojejunostomy. In this patient, subtotal gastric resection was performed.

Dr. James Apostol: Our patient has had massive bleeding due to recurrent peptic ulcer after previous vagotomy and pyloroplasty. Subsequent work-up revealed a positive Hollander test which would indicate the cause of recurrence to be due to incomplete vagotomy. The distinct impression is gained from the literature that the surgical procedure of choice in this situation is subtotal gastrectomy. Completion of the vagotomy transabdominally would be technically difficult and even when performed transthoracically, would result in more failures to control the disease than subtotal gastrectomy. Vagotomy, on the other hand, would be the preferred surgical treatment of recurrent peptic ulcer after previous gastric resection. Therefore, we elected to perform the subtotal gastrectomy.

Dr. James Hines: This case brings up two very interesting points in ulcer surgery. The first is the completeness of a vagotomy when it is used in combination with a drainage procedure. Second, the effectiveness of the drainage procedure itself. The X-rays as they are shown here, appear to be that of a Heinecke-Mikulicz pyloroplasty rather than a Finney, in that the dog ear deformity shown here is typical of a post operative film of a Heinecke-Mikulicz pyloroplasty. These films seem to show some stasis and the narrowing of the outlet. A Finney pyloroplasty is a gastroduodenostomy. On cross section, a Finney pyloroplasty seems to have a large opening from the stomach into the duodenum, but in reality, the back wall is closed in towards the lumen using two layer closure and the front wall is turned in, in two layers, leaving a rather narrow slit. In some cases, the

Finney pyloroplasty can also obstruct. A Heinecke-Mikulicz pyloroplasty can obstruct if closed in two layers.

Dr. Joseph Weinberg of California did a great deal of work showing that the one layer, non-absorbable suture, was a preferable method of closing the Heinecke-Mikulicz pyloroplasty. Dr. Weinberg pointed out that a two layer closure tended to produce stasis. Our patient presented here had a Heinecke-Mikulicz pyloroplasty and was closed in two layers. The stasis that can result from a poor gastric outlet procedure leads to gastric stimulation and that, in turn, produces gastrin. The gastrin produced can act on the parietal cell mass in three ways: 1) by direct action; 2) through the blood stream and 3) mediated through the vagus nerves. In this particular patient, it has been shown that there were some vagal branches that were not severed. This patient, therefore, was a good candidate for recurrent ulcer disease in that there was some stasis and narrowing of the outlet and in addition, some vagal fibers were present to mediate the gastrin produced by the stasis.

Recurrent ulcer disease based on outlet obstruction, stasis and incomplete vagotomy can either be gastric or duodenal. In this particular case, the gastroscopist saw an ulcer on the lesser curvature of the stomach in the prepyloric region. This is a very common place for recurrent ulcer disease.

In the event a patient gets recurrent ulcer disease following vagotomy and a drainage procedure, it is much wiser to do a gastric resection than it is to attempt to re-vagotomize the patient through the abdomen. It is difficult to attempt through the dissection of the vagus nerves, in that the patient very often can be subjected to esophageal trauma. If a patient has a wide gastric outlet, one might consider doing a transthoracic vagotomy. In this particular case, the gastric outlet was poor and the vagus nerves had not been completely severed, so that operation of choice was to do a subtotal gastric resection of a Billroth II type. As I understand it, this was carried out and the patient had an uneventful post operative course. ◀

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Delayed Ovulation

BY MARTIN B. WINGATE, M.D., W. S. MICHAEL ARRATA, M.D., and LESLIE IFFY, M.D./CHICAGO

Evidence has accumulated in the last decade indicating that if ovulation is delayed an "overripe" ovum with pathologic potentialities may be produced. Although fertilization of such ova results in early miscarriage in most cases, some of these abnormal products of conception may escape early demise and manifest themselves at or around term as fetal malformation, defective chromosome constitution, placenta previa, or any combination of these abnormalities.

When ovulation is late the luteal phase is often shortened and steroidogenesis by the corpus luteum is deficient. In case of fertilization, delayed migration and implantation of the ovum often results in failure to suppress the next menstrual period. Thus, in a considerable proportion of such cases, a discrepancy between the estimated length of pregnancy, based on this fallacious "period," and the stage of development of the products of conception will exist. If recognized, this "post-conception bleeding," indicated by an unduly large uterus in comparison with the length of amenorrhea, may help to predict a high risk pregnancy.

Although it has been known for several decades that ovulation time could be subject to alterations under certain endogenous or environmental circumstances, the implications of such changes have attracted little attention. The possible correlations between ill-timed ovulation and infertility have received some consideration, but up to a few years ago it was generally con-

sidered that once fertilization had taken place the time of conception had no bearing on the further progress of gestation. This assumption has undergone re-evaluation recently, since investigations of causal factors in reproductive loss have provided substantial evidence indicating that the time of ovulation has a far-reaching effect on the outcome of pregnancy. Since this new concept has significant practical implications, a review of the relevant experimental and clinical observations appears justifiable.

"Premenstrual Conception"

Whereas in normal gestations amenorrhea almost invariably occurs immediately after fertilization, in the majority of cases of early spontaneous abortion and extrauterine pregnancy, there is apparent menstrual bleeding following conception. This incidence, first noted by Mall¹⁻³ over half a century ago, has been observed recently by several investigators of early embryos.⁴⁻⁹ In embryologic studies this phenomenon is indicated by the findings of embryos that are far too large for their menstrual age. Our own material showing the discrepancy is presented in Figure 1. It follows from our findings that the presence on examination of a uterus that is several weeks too far advanced in size in relation to the length of amenorrhea is likely to represent an error in calculating the stage of gestation because of postconceptional bleeding.⁸ Thus, the presence of such discrepancy may forecast an impending miscarriage or other reproductive abnormality.

Both early spontaneous abortion and extrauterine pregnancy are associated with a very high incidence of developmental anomalies.¹⁻³ Placenta previa is another condition in which an increased incidence of fetal defects has been reported.¹⁰ It is of interest, therefore, that a statistically significant discrepancy, between menstrual age and fetal weight, similar to what has been demonstrated in early abortion and ectopic gestation exists in many cases of low implantation of the placenta also.⁶ Table 1 presents a



Wingate

Arrata

Iffy

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Table 1

Menstrual Age	Average Fetal Weight in Normal Gestations According to Arey ¹	Average Fetal Weight in Placenta Previa	Number of Cases
28-29 weeks	1050-1200 G		
29-30 weeks	1200-1350 G	1610 G *	(5)
30-31 weeks	1350-1500 G		
31-32 weeks	1500-1700 G	1940 G *	(9)
32-33 weeks	1700-1900 G	2050 G *	(8)
33-34 weeks	1900-2100 G	2200 G *	(11)
34-35 weeks	2100-2300 G	2590 G *	(14)
35-36 weeks	2300-2500 G	2720 G *	(18)
36-37 weeks	2500-2700 G	2775 G *	(30)
37-38 weeks	2700-2900 G	3000 G *	(42)
38-39 weeks	2900-3150 G	3175 G **	(24)
39-40 weeks	3150-3400 G	3305 G ***	(28)
40-43 weeks	3400-3550 G	3510 G ***	(25)

Menstrual age in comparison with fetal weight in normal pregnancy and placenta previa. Note the unusually high average fetal weights with low implantation.

*Difference is statistically significant at the p 0.05 level.
 **Difference is statistically significant at the p 0.5 level.
 ***Difference is not significant statistically.

breakdown of our 214 investigated cases demonstrating this phenomenon caused by a high incidence of premenstrual conceptions.

Although the frequency of placenta previa is only about 0.5% in third trimester gestations,⁶ its rate of occurrence is about 10% in early spontaneous abortions.¹¹ Assuming that the frequency of early abortion is about 10% of all gestations, it can be calculated that approximately two-thirds of all cases of placenta previa result in an early miscarriage. Consequently, the coincidence of low implantation and fetal malformation is likely to be much higher than the 3-fold increase noted by Greenhill¹⁰ in last trimester cases of placenta previa.

“Delayed Ovulation,” “Overripeness,” and “Chromosome Defects”

Embryologic studies quoted earlier have drawn attention to the possibility that the apparent menstrual bleeding that so frequently follows fertilization in pathological pregnancies is the consequence of a delayed (postmidcycle) ovulation.⁵⁻⁸ This finding was supported by published case reports of early spontaneous abortion in which conception was related to a single intercourse the time of which had been known to the patient. In the majority of such cases, fertilization occurred several days after the midcycle.⁷ Support for this concept was recently provided by the studies of Hertig.¹² In a retrospective review of his unique collection of 34 early ova Hertig found that, although of 13 ova fertilized on or before the 14th day of the intermenstrual cycle, 12 appeared normal microscopically; of the 21 eggs fertilized on or after the 15th cycle-day not less than 13 showed morphologic abnormalities of cell division.

The experiments by Fugo, Butcher, and Blue¹³⁻¹⁵ who produced delayed ovulation in rats by the administration of nembutal add further support to these findings. Butcher and co-workers demonstrated manifold increases in early embryonic demise, anatomic developmental defects, and chromosomal anomalies when ova of delayed ovulations became fertilized.

The significance of ovulation time, as compared with other factors, in the genesis of human pregnancy anomalies is difficult to evaluate accurately because late ovulation itself may be a result of other pathologic influences.⁸ However, the available evidence suggests that whether alone or in association with other components it is a significant causative factor in reproductive wastage.

Extensive investigations have been directed towards defining the factors responsible for chromosomal anomalies. Among the variables implicated are the effects of radiation, drugs, infections (particularly viral), patterns of inheritance, diet, geographical location, variations in climate and temperature, and maternal and paternal age. The results of these studies are often conflicting and it is common to conclude that there is no one single cause of such anomalies.^{4,16-18}

Early abortion is associated with a high incidence of aberrations of chromosomal number or constitution.^{1,3,4,8,12,17,19-27,29} It is likely that when more refined methods of cytogenetic evaluation become available an even greater percentage of rejected pregnancies will be found to be associated with such abnormalities. Experimental and clinical evidence quoted earlier indicate that there is a limited period of time during which fertilization of an ovum is likely to

result in the development of a normal fetus and in the progression of a normal pregnancy. If for any reason ovulation is delayed, the ovum becomes "overripe."²⁹ Such an ovum is apparently more vulnerable to a variety of harmful influences and its fertilization may lead to various reproductive anomalies.^{5-8,12-15,17,25,29-34,36-40}

Overripeness of the ovum may be "preovulatory" with prolonged retention of the egg inside the follicle,^{5-8,13-15,17,29,36-38,40} or "postovulatory." In the latter case ovulation time may be normal but a delay in fertilization occurs as the egg travels in the fallopian tube.^{29,31-33,39} Both these phenomena have been found to give rise to errors of chromosomal division in experimental amphibians and mammals^{29,37} and the same causal relation seems to exist in man.^{8,17,29}

Anatomic and cytogenetic studies in early human spontaneous abortions indicate a close association between the incidence of embryonic maldevelopment and chromosomal aberrations.^{4,17,19-21,24-27,29} Later abortions, particularly those in the second trimester of pregnancy, have a much lower incidence of chromosomal and anatomic anomalies and when present these defects are less severe and often are compatible with postnatal survival.²⁷

Mikamo¹⁷ found gross structural abnormalities in 100% and chromosomal defects in 75% of his recent series of abortions of less than four weeks of age, whereas Wingate²⁵ noted 29% of anatomic and 3% of chromosomal anomalies in 48 midtrimester abortions. Many of these defects were compatible with continued development and survival.

The most frequent cytogenetic abnormalities reported are aberrations of the chromosome number of both the autosomes and sex chromosomes. These include sex chromosomal monosomy, single trisomy of sex chromosomes or autosomes, triploidy, double autosomal trisomy and tetraploidy. Autosomal monosomy and mosaics have rarely been found.⁴

A number of different mechanisms have been postulated to account for the variety of changes in chromosome number. They include C mitotic duplication, endomitosis, endoreduplication, nondisjunction and anaphase lagging. The most important mechanism is nondisjunction. It may affect meiotic or mitotic division and is thought to give rise to the majority of monosomies and trisomies and a large proportion of polyploidies and mosaics. Nondisjunction has been repeatedly observed to cause anomalies of chromosomal division in experimental models of "overripe-

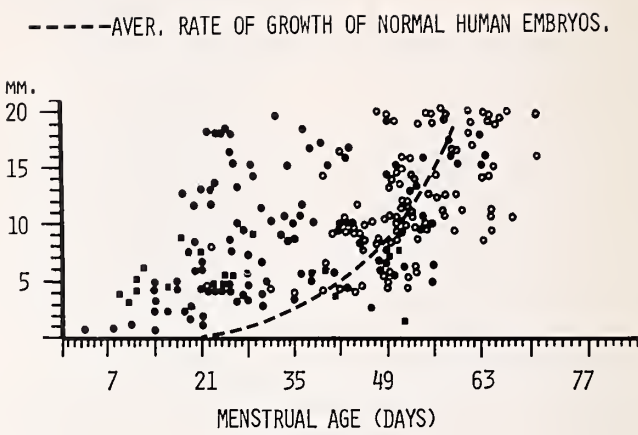


Figure 1

Correlations between menstrual age (horizontal line) and embryonic crown-rump length (vertical line) in artificially interrupted normal pregnancies, spontaneous abortions and ectopic gestations. Note that the size of embryos from therapeutic abortions correlates closely with average standards,^{7,9,46} whereas most spontaneously aborted and ectopic specimens are far bigger than their menstrual age would allow one to expect.

- Embryos obtained by artificially induced abortion (101 cases).
- Spontaneously aborted embryos (20 cases).
- Ectopic embryos (intact and fresh specimens exclusively embryonic death at the time of, or immediately before, the operation) (107 cases).

ness" of the ovum.^{17,29,37,38}

The earliest demonstration of the effects of the fertilization of overripe ova on chromosomal division and embryonic development was obtained in frogs and toads.^{17,36} Subsequently, similar observations on the result of delayed fertilization have been documented in guinea pigs, rats, and rabbits.^{13-15,29,31,32,40} There is a high incidence of abnormal ova, unfertilized eggs, failure of implantation and abnormal fetal development in such cases. Chromosomal studies frequently show monosomy, trisomy, polyploidy, and mosaicism. Abnormal chromosomal behavior appears to occur in both the first and second meiotic stages of cell division. There is movement of one or two undivided tetrad or diad chromosomes to the outer or inner pole, lack of polarization, and regressive changes in the chromosomes themselves. Degeneration of the spindle fibers is an important mechanism characterized by fragmentation and disintegration, especially at the poles ends, and random scattering of chromosomes. These changes lead to nondisjunction.

In addition to the foregoing, overripeness may be reflected by undue enlargement of the ovum

with thinning and weakening of the cell membrane.³⁴ This phenomenon appears to result in decreased resistance to penetration by spermatozoa.

Recently Lejeune⁴¹ has postulated that "underripeness" of the ovum may be responsible for the autosomal trisomy of Down's syndrome. This suggestion was based on a series of cases associated with conception on or around the ninth cycle-day.

Fertilization by abnormal sperm also may be a factor in the etiology of development and chromosomal anomalies. However, the available evidence appears to indicate that previously overripeness of the ovum is a far more important cause of such aberrations.¹⁷

Endocrinologic Considerations

For normal ovulation to occur a complex series of events must take place on time and with optimal ratios of the components involved. A minor defect in this mechanism may be expressed as a delay of ovulation,³⁰ whereas a gross physical or emotional stress may suppress ovulation entirely.⁴²

Early stages of follicular growth are relatively independent of pituitary stimulation.⁴³ However, after having developed through the antrum and theca interna stages, the follicle becomes responsive to stimulation by the follicle-stimulating and luteinizing hormones, FSH and LH respectively.⁴⁴ Appropriate cyclic changes in the secretion of these hormones, and particularly the midcycle surge of LH, induce a rapid growth of the follicle as well as the delicate process of the first meiotic division.

Premature ovulation can be produced experimentally by treatment with high doses of LH. It is also possible by stimulation of certain parts of the brain to cause the pituitary gland to secrete enough LH to induce a premature ovulation. If, for any reason, gonadotropins are not available in adequate amounts or in a proper ratio when the follicle is ready to rupture, ovulation is suppressed. Subsequent reestablishment of a favorable milieu might stimulate follicular rupture at a later date, thus causing the release of an overripe ovum. This phenomenon is usually associated with a shortened luteal phase. The fact that periods may remain fairly regular in anovulatory cycles indicates that there is no absolutely constant time correlation between ovulation and subsequent menstruation. Therefore, delayed follicular ripening may not alter significantly the time of onset of the subsequent period and may result in a secretory phase that

is less than 14 days in duration, a frequent incident in those cases of infertility generally attributed to "luteal phase defect."³⁰

The factors causing, preventing, and influencing ovulation are already the subject of extensive study. The relevance of these problems to overripeness and thus to reproductive wastage appears to be a new facet of this field of research.

Clinical Implications

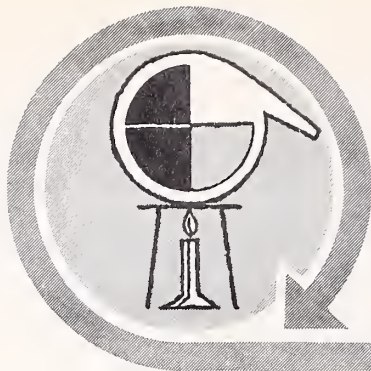
That premenstrual conception often results in miscalculation of the length of gestation has been emphasized earlier in connection with early abortion, ectopic pregnancy and placenta previa. Battaglia and associates⁴⁵ found an increased incidence of perinatal loss in association with pregnancies in which fetal development was disproportionately advanced in comparison with menstrual age. They considered the possibility that the menstrual history might have been erroneous in these cases.

Lack of normal correlation between fetal size and menstrual age is particularly prevalent in elderly gravidae who often give birth to a mature baby several weeks before the calculated term.⁵ The rate of pregnancy anomalies is significantly increased in this age group.

The knowledge that in cases of early abortion and ectopic pregnancy the gestation may be in a relatively advanced stage without a corresponding history of amenorrhea is one significant practical implication in the understanding of the role of ovulation time in reproductive failures. The information that with placenta previa many fetuses appear 3-4 weeks older than the menstrual history would indicate is another important clinical application of the observations relevant to this concept. Nevertheless, it would be erroneous to consider the weight of the above-summarized information concerning the role of ovulation time in reproductive failure in the light of its applicability to current clinical practice. Instead, one should view this new knowledge in the broad spectrum of medical endeavor to comprehend the nature and causes of disease. Recent advances with respect to the role of abnormal ovulation time in reproductive wastage represent significant progress in our understanding of the mechanism of several types of pregnancy abnormalities. The main practical benefits of this new knowledge are still forthcoming. ◀

References

A complete bibliography for "Delayed Ovulation" may be obtained by writing to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.



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By PAUL DEHAEN

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Dosage: Adjust to clinical response.
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Nonproprietary Name: Tetracycline HCl
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Doctor's News

MAJOR HEALTH PROPOSALS ASSIGNED TO SUBCOMMITTEES—This summer public hearings will be held concerning Illinois health bills, H.B. 1403, S.B. 955 and S.B. 1128.

The Certificate of Need (H.B. 1403) has been assigned to the Senate Public Health Committee. This bill provides that all licensed health facilities must be coordinated with a statewide health plan developed by the Comprehensive Health Planning Agency. In addition, expansion or providing of new services by licensed health facilities must be based on demonstrated need.

Health and Social Services Reorganization Act of 1973 (S.B. 955) eliminates the Illinois State Departments of Public Health, Mental Health, Public Aid & Children and Family Services; these departments would merge to become the Department of Health and Social Services. This bill has been assigned to the House Human Resources Committee.

Health Maintenance Organization Act (S.B. 1128) is a significant attempt to regulate HMO's in Illinois.

Anyone who desires information concerning the time and place of the hearings should contact the ISMS Regional Office 217-528-5609.

NEW PROFESSIONAL LIABILITY PROGRAM ATTRACTS 3,400—Illinois physicians are enrolling in the new ISMS professional liability program, which is underwritten by the Hartford Company and administered by Johnson and Higgins. The new program went into effect June 1 and has attracted 3,400 physicians. According to Johnson & Higgins, all applicants are automatically covered the first 120 days. Due to the high volume of applications there is a short waiting period for the policies.

VD FILMS AVAILABLE—Pfizer Laboratories has supplied two films on venereal diseases for the use of the ISMS membership. The films, "A Plague on Our House" and "Gonorrhea" are available upon request to the Scientific Speakers Bureau, Illinois State Medical Society, 360 N. Michigan Ave., Chicago, 60601.

ACCREDITATION OF CONTINUING MEDICAL EDUCATION—The Illinois CME Accreditation Program is now in full operation; the first site visit was held June 26, 1973, and another 25 applicants are at various stages of the process. Eligible for accreditation are the CME programs of hospitals, county medical societies, State and Chicago specialty societies.

For full information, request the ISMS brochure, "*Guidelines & Principles for Continuing Medical Education Programs.*" Write to: ICCME, 360 N. Michigan Avenue, Chicago, 60601.

PHYSICIANS IN THE NEWS—**Alexander M. Schmidt, M.D.**, has resigned as Dean of the Abraham Lincoln School of Medicine, University of Illinois College of Medicine, to accept an appointment as Commissioner of the Food and Drug Administration, Department of Health, Education and Welfare, Washington, D.C. **Melvin Sabshin, M.D.**, will be the Acting Dean at the Abraham Lincoln School of Medicine.

Eugene Rogers, M.D., has been appointed Chairman of the Department of Rehabilitation Medicine at the University of Health Sciences/The Chicago Medical School. In addition, Dr. Rogers will be serving as Chairman of the Department of Rehabilitation Medicine at Mount Sinai Hospital Medical Center and Schwab Rehabilitation Hospital.

Jerome H. Jaffe, M.D., former head of Illinois Drug Abuse Program, has resigned as Director of the Federal Government's Special Action Office for Drug Abuse Prevention.

William C. Scrivner, M.D., Belleville obstetrician and ISMS President and **Clement R. Brown, Jr., M.D.**, Director of Medical Education at Mercy Hospital and Medical Center, Chicago, were named to the 11-member National Professional Standards Review Council.

Teachers of the Year at the Loyola Stritch School of Medicine were **John F. Moran, M.D.**, Villa Park, cardiologist and **Harry L. Messmore, M.D.**, Hinsdale, Chief of Hematology.

The 1973 class of Rush Medical College honored **Stuart Levin, M.D.**, with The Phoenix Award for outstanding teaching. He is Associate Professor of Medicine at Rush Medical College and Senior attending physician at Presbyterian-St. Luke's Hospital. Honorary degrees bestowed at the Rush Medical College commencement included **Robert J. Glaser, M.D.**, Doctor of Humane Letters and **Mark H. Lepper, M.D.**, Doctor of Science. Dr. Glaser is President of the Kaiser Family Foundation and Dr. Lepper, former dean of Rush, was recently appointed Coordinator, Health Services and Chairman, Comprehensive Health Planning Board, State of Illinois.

David Movitz, M.D., has been named Associate Medical Director of Mary Thompson Hospital, Chicago. **William H. Shlaes, M.D.**, and **Irving R. Savin, M.D.**, were recently elected Vice-President and Secretary respectively of the medical staff of Louis A. Weiss Memorial Hospital, Chicago. **Jaime L. Fridman, M.D.**, has become Director of Prairie Place Medical Clinic, a new Chicago medical facility specializing in the treatment of children. **Seymour Diamond, M.D.**, has been elected President of the National Migraine Foundation. All of the above physicians are on the faculty of the University of Health Sciences/The Chicago Medical School.

New Fellows of the American College of Physicians are: **Murray C. Brown, M.D.**, Chicago; **Paul R. Eggum, M.D.**, Chicago; **Maurice A. Mufson, M.D.**, Chicago; **Veerasamy K. G. Pillay, M.D.**, Chicago; **Louise J. Riff, M.D.**, Chicago; **Arthur H. Rubenstein, M.D.**, Chicago; **Lawrence D. Edwards, M.D.**, Chicago; **H. Paul Carstens, M.D.**, Palatine; **Takashi Okuno, M.D.**, Park Ridge; **Robert E. Slayton, M.D.**, River Forest; **Col. Richard B. Byrd, M.C.**, USAF, Scott Air Force Base, Belleville and **William V. Blazek, M.D.** **Beg Your Pardon**—**Helmut Blumenthal, M.D.**, was omitted from the June issue as among the many physicians honored for their 25 years of service to the University of Illinois College of Medicine. Dr. Blumenthal has served his years in the Department of Otolaryngology.

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Your experience with Lasix[®] (furosemide) has proven its usefulness in office practice

Lasix[®] furosemide Tablets/Injection

WARNING—Lasix (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix (furosemide) is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix (furosemide) is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

If the gastrointestinal absorption is impaired or oral medication is not practicable for any reason, Lasix is indicated by the intramuscular or intravenous route. The intravenous administration of Lasix is indicated when a rapid onset of the diuresis is desired, e.g., acute pulmonary edema.

Parenteral administration should be reserved for patients where oral medication of Lasix (furosemide) is not practical.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix (furosemide) alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities the drug is contraindicated in women of child-bearing potential.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium-depleting steroids.

Frequent serum electrolyte, CO₂ and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix (furosemide).

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion. In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

Cases of reversible deafness and tinnitus have been reported following the injection of Lasix. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic injection dose of 1 to 2 ampules (20 to 40 mg.). Transient deafness is more likely to occur in patients with severe impairment of renal function and in patients who are also receiving drugs known to be ototoxic. Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour postprandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix (furosemide) may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue oral Lasix for one week and parenteral Lasix two days prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

Cases of reversible deafness and tinnitus have been reported. These adverse reactions occurred when Lasix Injection was given at doses exceeding several times the usual therapeutic dose of 1 to 2 ampules (20 to 40 mg.). (See "PRECAUTIONS.")

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, lightheadedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

Transient pain after intramuscular injection has been reported at the injection site.

DOSAGE AND ADMINISTRATION

Oral Administration—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg.) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced. If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg.) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg.) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given

once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). The dose of Lasix may be carefully titrated up to 600 mg. per day in those patients with severe clinical edematous states. Higher doses are currently under investigation.

The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg./day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

Hypertension—The usual dose of Lasix (furosemide) is one tablet (40 mg.) twice daily both for initiation of therapy and for maintenance. Careful observations for changes in blood pressure must be made when this compound is used with other antihypertensive drugs, especially during initial therapy.

The dosage of other agents must be reduced by at least 50 per cent as soon as Lasix is added to the regimen to prevent excessive drop in blood pressure. As the blood pressure falls under the potentiating effect of Lasix, a further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary. It is further recommended, if one tablet (40 mg.) twice daily does not lead to a clinically satisfactory response, to add other hypotensive agents, e.g., reserpine, rather than to increase the dose of Lasix.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

Parenteral Administration—The usual dose of Lasix is 1 to 2 ampules (20 to 40 mg.) given as a single dose, injected intramuscularly or intravenously. The intravenous injection should be given slowly (1 to 2 minutes). Ordinarily, a prompt diuresis ensues. Depending on the patient's response a second dose can be administered two hours after the first dose or later.

If the diuretic response with a single dose of 1 to 2 ampules (20 to 40 mg.) is not satisfactory, e.g., in a patient refractory to maximal doses of thiazides, the following schedule should be used under careful medical supervision: Increase this dose by increments of 1 ampule (20 mg.) not sooner than two hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily. Parenteral administration should be reserved for patients where oral medication is not practical. Parenteral therapy with Lasix can be replaced by treatment with Lasix Tablets as soon as this is practical for continued mobilization of edema.

Acute Pulmonary Edema—Since the diuresis evoked by Lasix given intravenously commences within five minutes and leads to an intensive diuresis, the treatment of patients with acute pulmonary edema with Lasix (furosemide) intravenously has proven particularly valuable.

The following schedule is recommended: 2 ampules (40 mg.) of Lasix are to be slowly injected intravenously immediately. Then this dose should be followed by another 2 ampules (40 mg.) one to one and one-half hours later if that is indicated by the patient's condition.

If deemed necessary, additional therapy (e.g., digitalis, oxygen) can be administered concomitantly.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

HOW SUPPLIED—Lasix (furosemide) Tablets are supplied as white, monogrammed, scored tablets of 40 mg. in amber bottles of 100 (FSN 6505-062-3336), 500, and Unit Dose 100's (20 strips of 5). Lasix (furosemide) Injection is supplied as a sterile solution in 2 ml. amber ampules, boxes of 5 and 50. Each ml. contains 10 mg. furosemide (with sodium chloride for isotonicity and sodium hydroxide to make the solution slightly alkaline).

Note: Exposure to light may cause slight discoloration which, however, does not alter potency.

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REG. TM. FARBERWERKE HOECHST

Editorials



Why go to Medical School

Young people usually select a medical career for various reasons. Among these are status, financial reward, security of employment, personal authority, independence, scientific interest, and a desire to serve mankind. In general, physicians enjoy a good reputation in the community, make a comfortable living, and are able to enjoy the finer things of life. Since it takes "brains" to earn a medical degree, the majority are respected also for their intelligence. The drama of medicine also is an attractive.

In contrast, young adults may be deterred from entering the profession by the long period of training, number of examinations, ethics, adverse working conditions, growing governmental interference, paperwork and long hours. I've seen students drop out after the first week, because they could not cope with morbid situations or, perhaps, they just got "cold feet." ◀

T. R. VanDellen, M.D.
Editor

Guest Editorial

The Goose That Laid The Golden Egg

Once upon a time there was a country that had the best medicine in the world. Physicians and other medical specialists came from all over the world to learn. People in that country were proud of their medicine. The doctors worked hard to care for their patients and to upgrade and improve the level of medicine. They took refresher courses, established areas of specialization and developed examining boards which would insist that specialty qualifications be high. In general, the doctors were a dedicated lot. Some of them made a lot of money; but very few made as much as they would with the same brains and same diligence applied to business or industry.

But some people were dissatisfied. Some thought doctors should be more conveniently located. Some were disappointed that every doctor was not a perfect father figure. Some thought that they should get medical care free. Some were misled by odd-ball statistics into thinking that the infant mortality rate was higher than it really was. And there were some other complaints.

So, despite the pride the country had in its medicine, there were little splinter groups who wanted this or that changed. And a lot of politicians saw an area where they thought that they could improve on medicine by changing the laws of the land. Some promised to get it wholesale.

Others promised to get it free. They had the power to write laws and they were easily hypnotized by their own eloquence.

So a scant majority of the politicians in office at that moment in history got busy writing laws without heeding the advice and counsel of doctors. They took the stand that if the doctors and the field of medicine didn't fit the laws, then the doctors and the field of medicine would have to change. So they wrote Medicare and Medicaid. Unfortunately, these laws didn't turn out exactly as they had predicated. Then, they said that the doctors were responsible for the failures. So they started writing more laws.

In the end, it just didn't work out that the politicians could get it wholesale or free. There was a strong suggestion that their tampering had slowed the rate of improvement of medicine. Splinter groups were still complaining. So the alarmed politicians blamed the doctors more and wrote harsher and harsher laws.

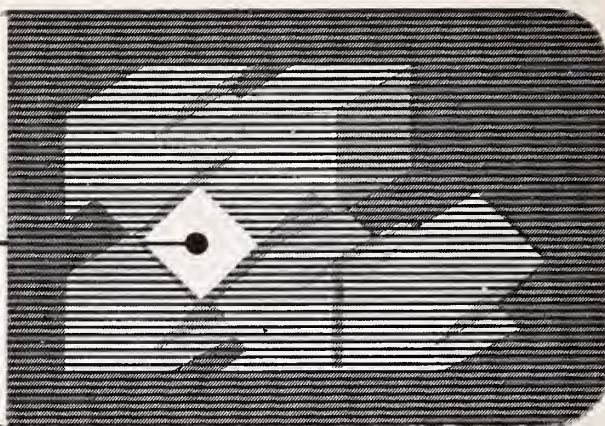
This state of affairs antagonized and discouraged the doctors. They began to look around for ways of beating the system rather than ways of practicing top-notch medicine.

And that, dear children, is how they killed the goose that laid the golden egg.

W. David Steed, M.D.
Oak Park

Trauma Center

DAVID R. BOYD, M.D.C.M., Editor



Traumatic Rupture of Thoracic Aorta

BY EDWARD H. SHARP, M.D., WILLIAM D. COX, M.D., and
RANDALL MULLIN, M.D./ROCKFORD

With the increasing number of high speed accidents, there will be an increase in traumatic rupture of the aorta. Fifteen to 20% of these patients will live to be examined by a physician.¹ If this physician suspects the condition, emergency aortography can confirm the diagnosis and modern cardiovascular surgical techniques give such a patient a good chance for survival. However, if the diagnosis is not suspected, such patients might be observed in hospitals that lack the facilities to carry out the proper treatment. These patients may well be *in extremis* before the diagnosis is suspected and will succumb before transfer to an adequate facility can be accomplished.

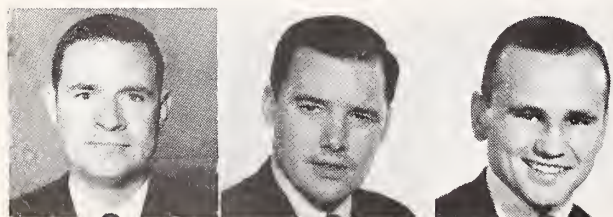
In the case reported, the diagnosis was suspected by the family physician first seeing the patient. He referred the patient to an institution that had the capabilities of making the definitive diagnosis and of carrying out definitive treatment. The physician suspected a ruptured aorta

on the basis of the chest X-ray (Figure 1); but his index of suspicion was high since in the previous two weeks he had attended two autopsies on patients who had died of a ruptured traumatic aneurysm. It is this type of alertness and training which can lead to the saving of lives following accidents.

Case Report

G. B., an 18-year-old male, was involved in an automobile accident when his car was struck head-on by another car; the patient was thrown out of the automobile. The State Police noted the patient's steering wheel was bent. The patient was taken to the nearest hospital where the family physician examined the patient, noted his dyspnea, and because of a suspected widened mediastinum on the chest X-ray (Figure 1), referred the patient to St. Anthony Hospital, Rockford, with a tentative diagnosis of a traumatically ruptured aneurysm of the descending aorta.

When seen in the emergency room, the young man was quite pale, dyspneic, and perspiring. His blood pressure ranged between 90/40 and 120/60 mm Hg, with an admission systolic pressure of 90 mm Hg. There was a tenderness to pressure over the midsternal area but no fracture was felt. Other than multiple abrasions of the left knee and right ankle there were no other significant physical findings. The patient's admission white count was 39,000 with a shift to the left, and a hemoglobin of 13.8 grams. The chest X-ray again was suggestive of slight widening of the mediastinum. A transfemoral aortogram was carried out which confirmed the diagnosis of a ruptured descending aorta (Figure 2).



Sharp

Cox

Mullin

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RANDALL MULLIN, M.D., is a resident in family practice at the Rockford Medical Education Foundation.



Figure 1. Widening of the mediastinum was suspected but not extensive enough to be obvious.

The patient was transferred from the X-ray department to the operating room. In surgery he was placed in a right lateral position and the left chest was opened through the fifth left intercostal space. Blood pressures in the upper and lower extremities were monitored with intra-arterial cannulas and the venous pressure was monitored with a central venous cannula inserted into the right internal jugular vein. On opening the pleural space there was free blood. An area of the aorta just distal to the ductus measuring one and one half inches was found to be somewhat mushy. The left inguinal area was opened and an arterial cannula was inserted into the femoral artery as well as a venous cannula inserted into the femoral vein. The patient was heparinized and the venous blood was drawn off by gravity into the heart-lung machine, oxygenated and returned to the artery.²

Throughout the procedure the mean pressure in the lower extremity was maintained at approximately 35 mm of mercury with a flow measuring on the average of 2,000 cc's per minute. The area of the ruptured aorta was resected and a 16 millimeter teflon graft, one and one half inches long was sutured with 4-0 Mersilene to bridge the defect and reestablish flow. Reversal of the heparin was carried out with protamine, the chest was closed, and the vessels were repaired. The patient was taken to the recovery room in an excellent condition and had an uncomplicated postoperative course.

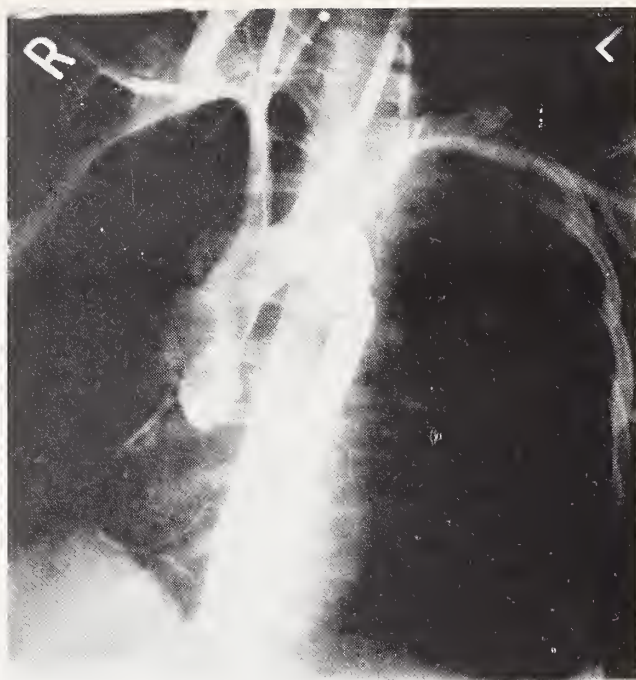


Figure 2. The aorta is clearly disrupted distal to the left subclavian artery.

Discussion

Excellent reviews of the traumatic rupture of the thoracic aorta have appeared in the literature and another such review is not necessary.^{3,4} This young patient, the victim of a high speed accident, was thrown from the automobile, disposing him to this condition.⁵ Examination of such patients may reveal signs of mediastinal compression, but physical findings can indeed be minimal. "The most important aspect of diagnosis is suspicion of the condition."⁶ The most important test is a routine PA and left lateral chest X-ray searching for mediastinal widening.⁷ Other features which may enhance the examiner's clinical suspicion are chest pain, cough, dyspnea, cyanosis, hemoptysis, dysphagia, paralysis of recurrent laryngeal nerve, development of a Horner's syndrome, presence of hemorrhagic shock, hemothorax, development of a systolic or continuous murmur, development of a pseudo-coarctation syndrome with acute hypertension, and occlusion of the aorta with resulting paraplegia and anuria.

In this case, the first examining physician had a high index of suspicion following previous training experiences. The chest X-ray with minimal mediastinal widening was enough to refer this patient to an institution with aortography facilities and surgical capabilities to repair the defect. The result was a successful replacement of the completely severed aorta and a benign postoperative recovery.

(Continued on page 75)



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

— first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

Wednesday's child is full of woe"

It need not be this way for the MBD child.

He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD—Minimal Brain Dysfunction—can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.¹

Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference
1. Charlton, M. H.: *NY State J Med* 16:2058 (Aug 15) 1972.

**Ritalin® hydrochloride ©
(methylphenidate hydrochloride)**

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established. Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (i.e., weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored. Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states. Ritalin may lower the convulsive threshold in patients with or without

prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.



PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been

reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.

In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (eg, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug. Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued. Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

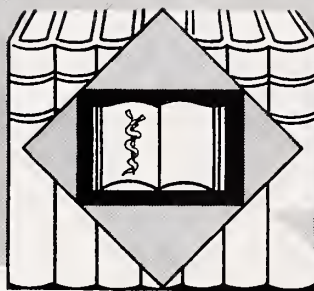
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

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Ritalin®
(methylphenidate)
only when medication
is indicated

C I B A

the doctor's library



THE BOOK FOR PARENTS—EYE MUSCLE PROBLEMS IN CHILDREN. By Edward G. Fortier, M.D. Roselle Publishing Company, Roselle, 1962. (158 Pages, 15 color illustrations, Price \$7.50).

One of the most difficult tasks in an ophthalmologist's daily practice is explaining to the parents of his strabismic patients what is wrong with their child and what treatment is indicated. This book is one method of reducing the requirement on the doctor's time for such communications. There are several books and educational films available to fill this need.

All these methods have one big problem: there are a number of schools of treatment for eye muscle problems in children. No single book or movie can go into much detail without contradicting the ophthalmologist's chosen methods of treatment. The physician who advises his parents to purchase this book or supplies it to them, may find himself in a situation where the usual questions are answered; but new and more disturbing questions concerning his choice of therapy are raised.

In comparison with the other sources available to fill this need, this book is exceedingly detailed. At the same time this may be a disadvantage since it may not be readily understood by the average parent.

For the above mentioned reasons we would recommend that ophthalmologists read this book for themselves before loaning a copy to, or recommending the purchase of a copy by, parents of their strabismic patients. Similarly, pediatricians and family physicians should not recommend that parents purchase this book unless the ophthalmologist to whom they refer such patients also recommends it. ◀

*J. Romano, C.O.
P. Romano, M.D.*

Children's Memorial Hospital, Chicago

HEREDITARY RETINAL AND CHOROIDAL DISEASES, VOLUME I—EVALUATION. By Alex E. Krill, M.D., Harper & Row Publishers, Hagerstown, Maryland, 1972 (354 pages).

This is the first of three volumes on this subject, the second and third of which will cover specific disease entities. At the time of publication the author had achieved real prominence in the field of ophthalmology as a result of clinical and experimental work which he had carried out in the area described by the title. It is indeed unfortunate that Alex E. Krill, M.D., died in an airplane accident shortly after the publication of this volume. Because of his enormous contributions to ophthalmology, his co-workers and associates at the University of Chicago promise that the next two volumes will be published as scheduled.

This first volume on methods of evaluation includes a rather thorough and up to date discussion of general genetics as well as a discussion of some of the specific diseases as genetics applies to them.

The following chapters cover in detail, with historical background and excellent illustrations, a variety of tests peculiar to ophthalmology and the study of these diseases: Fluorescein retinal angiography, dark adaptometry, electroretinography, electro-oculography, the visual evoked response and the evaluation of color vision.

As it locates in one volume all the latest information concerning these various tests, this volume is of real value to all ophthalmologists' and will certainly be of interest to geneticists and other persons who work in the area of visual physiology. ◀

Paul E. Romano, M.D.

Children's Memorial Hospital, Chicago



Placidyl® (ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting; gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 307454



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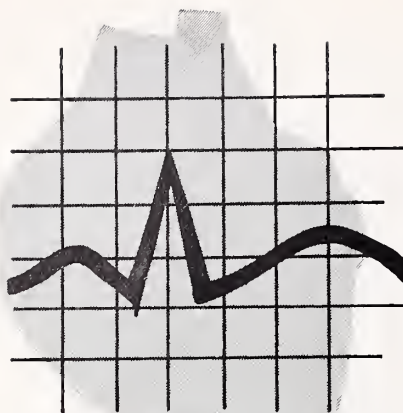
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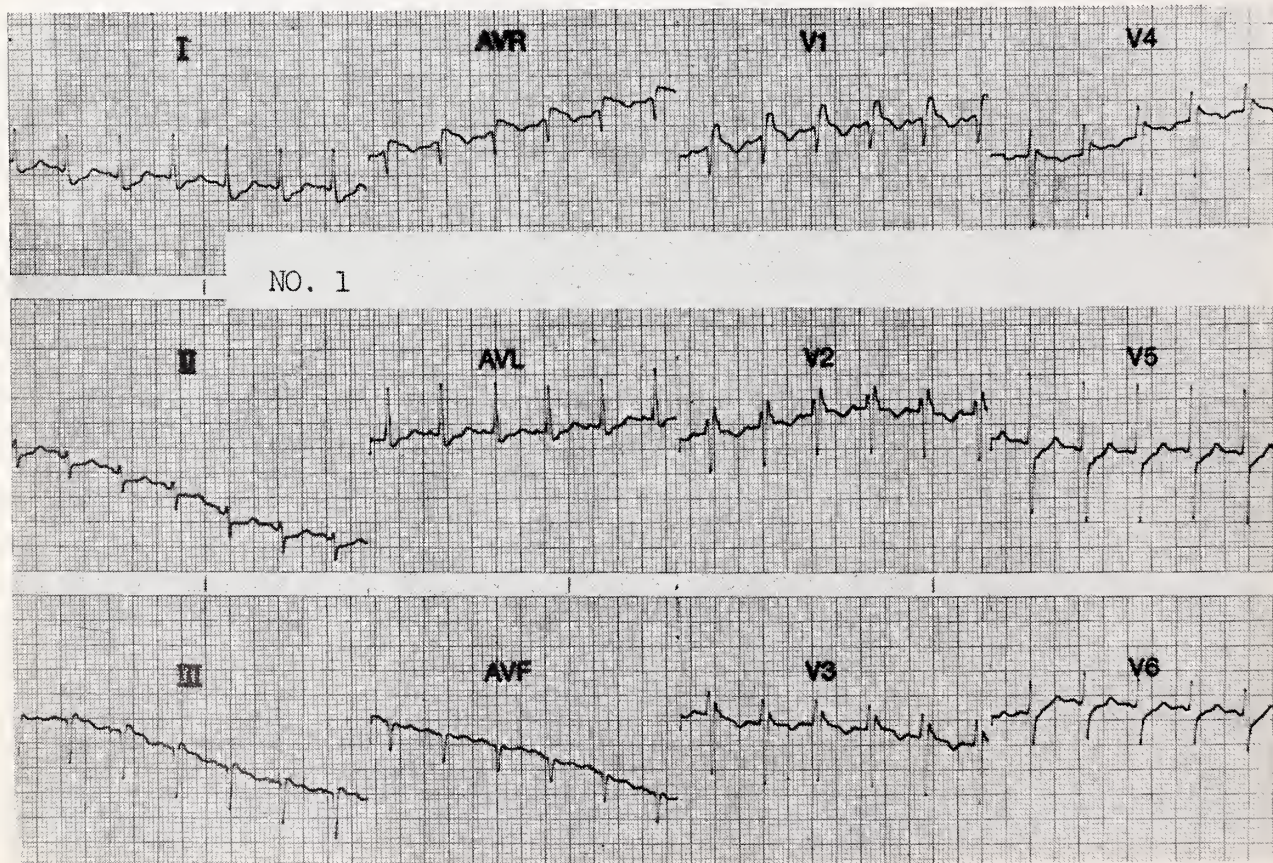
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ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine

A 79-year-old lady suddenly developed retrosternal discomfort with breathlessness. She was seen in the emergency room. On examination she was found to have large "a" waves in the jugular venous pulse. S₂ was widely split but varied with respiration. No other abnormalities were found.



Questions:

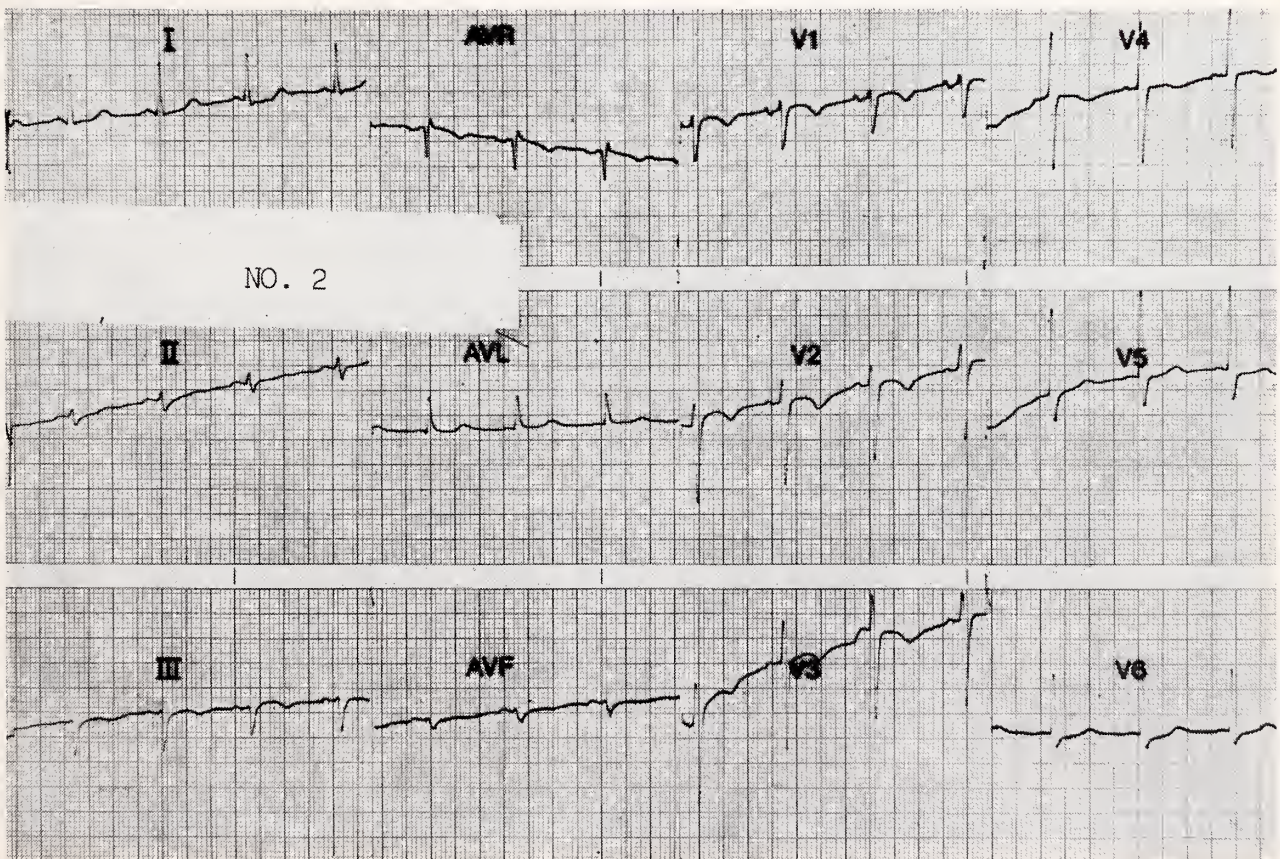
1. The electrocardiogram taken when she was first seen (No. 1) demonstrates the following abnormalities except:

- a) RBBB, complete
- b) Sinus tachycardia
- c) ST-T changes suggestive of right ventricular strain
- d) Left axis deviation
- e) Right axis deviation

2. The comparison of tracing No. 1 with the electrocardiogram taken 3 days later (No. 2) would suggest the following clinical diagnosis:

- a) Acute myocardial infarction
- b) Tietze's syndrome
- c) Acute esophagitis
- d) Pulmonary embolism
- e) Pneumonia

(Answers on page 73)



The Use and Abuse of Antibiotic and Chemotherapeutic Remedies

BY MARTIN H. SEIFERT, M.D./WILMETTE

There are certain advantages to being old enough to have practiced medicine before the advent of the therapeutic miracles represented in the drugs that shall be discussed here.

- It was possible to witness the natural course of infectious diseases, which it is so hard to teach to students today.
- These remedies appeared one by one, and we learned the uses and limitations of each one individually.

Now the student is faced with a veritable array of drugs and must learn them all at once.

When we had only sulfanilamide I saw the first hemolytic streptococcal meningitis leave the Evanston Hospital alive. I also determined that in streptococcal sore throat and in scarlet fever, the streptococci persisted as long in the throat after treatment with sulfonamides, as they did before (1938). Dr. Paul Rhoades (1938) in a series of cases of streptococcal sore throat treated alternately with aspirin and sulfonamides. He had better results in the aspirin treated cases; yet, in 1967 the Public Health Service was constrained to issue a letter to physicians suggesting that they *not* use sulfonamides in the treatment of sore throats.

We all have seen the mortality in lobar pneumonia, bacterial meningitis, and bacterial endocarditis dwindle. At the same time we have witnessed, (some of us with alarm), the increasing proportion of even college-age groups, sensitized to one or more of these valuable remedies, and at the same time noted the increasing species of bacteria becoming resistant to one after another of the drugs. I am convinced that much of these two phenomena are due to the indiscriminate use of these "wonder drugs."

I am reminded of the 51-year-old woman who was referred to me with meningococemia and epidemic meningitis, along with a note to the effect that she was sensitive to all sulfonamides

and antibiotics that had been out over six months. An experimental antibiotic I brought out from Cook County Hospital stopped the infection, but I believe she already had polyarteritis. The sad part of the story was that she had had no known disease since the first sulfonamide was used, for which any antibiotic or chemotherapeutic remedy would have been of any value.

We have witnessed the advent of "L" forms of bacteria, the production of a penicillin-destroying enzyme by staphylococci and more recently the destruction of synthetic penicillinase resistant penicillins by staphylococci,¹ the development of antibiotic resistance in shigella, salmonella,² E. coli, gonococci, and even Group A Beta hemolytic streptococci to tetracyclines and lincomycin.³ Also the resistance of meningococci to sulfadiazine is most distressing. Even mycobacterium tuberculosis has learned to resist the drugs used so successfully in the past to fight this disease.

At the same time we have seen the emergence of a group of "opportunistic" organisms, the Gram negative bacilli, yeasts, molds, and fungi to replace the more easily killed flora that gave us our problems before. Is it possible that even the weaker viruses have become more aggressive due to the wholesale slaughter of normal bacterial flora?

It would seem that I would like to go back to the pre-antibiotic era, and yet nothing could be farther from the truth. I can remember when a diagnosis of pneumococcal meningitis meant I had but one more useful purpose to serve for the patient. That was to sign his death certificate!

Then what are these remedies good for? As you all know, they will cure a great many bacterial infections, and save a great many lives. They do no *good* and frequently some *harm*, in most viral infections. Also in the presence of viral infections they do not *prevent* secondary bacterial infection, but merely cause the ones that occur to be more resistant to treatment.

Let us remember also that sometimes the antibiotics are life-threatening. We know this to be true of penicillin,⁴ chloramphenicol,^{5,6,7} and those that impair renal functions.⁸ It follows,



MARTIN H. SEIFERT, M.D., Wilmette, is the Associate Director of Northwestern University Student Health Service. Dr. Seifert, an internist, is Associate Professor Emeritus at Northwestern University Medical School and Attending Physician Emeritus at Evanston Hospital.

that in my own practice, I use these only when no less dangerous one will serve the purpose, and in the present of life-threatening infection.

When to Use Antibiotics

When then shall we use antibiotics? Antibiotics should be used only after we have proof or reasonable suspicion of a bacterial infection—having taken a history, examined the patient, and taken specimens for culture from whatever area, exudate, secretion, excretion, or body fluid that seems to harbor the infecting organisms.

If a throat is sore, culture it for streptococci. If it *really* looks like a strep throat, start treatment after taking the culture, and if *positive*—then treat long enough. If exudate is present, please culture for diphtheria, and if a membrane is present, make a *smear*.

Of the last 11 cases of diphtheria I saw at the Cook County Hospital, nine are dead. All were treated at home with penicillin, and none were cultured. One was dead on arrival, and the other eight lived two to twelve hours. This is a demonstration of the fact that while penicillin or erythromycin will kill the corynebacterium, they will *not* save the patient's life. He needs antitoxin *early* in the disease!

Much of the material for this article is based on such work as the Symposium of the New York Academy of Science⁹ and the new book *Microbial Therapy*,¹⁰ edited by Kagan. The years of experience at the Evanston Hospital communicable disease section and the Contagious Hospital at Cook County have also contributed.

I do not mean to say in my earlier statements that one will *never* use antibiotics without a firm diagnosis. It seems to me that Weinstein in his chapter on "common sense" (Clinical Judgment) in the diagnosis and treatment of etiologically undefined infections (Kagan)¹⁰ tells the story well:

1. Determination of epidemiologic background of a disease—such as, contact with birds in a pneumonic patient; lymphadenitis and encephalitis in a cat lover; fever, chills, jaundice and leukocytosis in a veterinarian or dog owner; fever and headache and neck pains in a pig farmer or raw milk drinker, should tell a story of etiology, as should an ulcer on a finger with axillary adenopathy in a rabbit hunter.

2. Occupation of the patient should help at times, the florist or arborist is more likely to have sporotrichosis.

3. Geography helps. Where has the pa-

tient been, who has visited him, and from where? Does he know of recent contact with similar illness? He may activate a malaria, even if he has not been in a malarial area for a year or more.

He brings out also, as do most authorities today, the fact that the use of combined antibiotic therapy as a substitute for common sense in the treatment of infection is questionable. Particularly bad is the use of a "fixed-dose" combination.

Staphylococcal Disease

In serious infections, one should probably start with large doses of a penicillinase resistant penicillin like methicillin—using 2 gm. every 4 to 6 hours or even up to 24 gm./day. If the patient is sensitive to penicillin one will *usually* be able to use cephalothin, which also resists penicillinase. Erythromycin and frequently vancomycin 2 to 4 gm. in 24 hours will handle some infections unresponsive to other drugs. If the organism proves to be sensitive to Penicillin G, this is certainly the treatment of choice in doses of 20 to 40 million units daily. For milder staph infections, erythromycin or oral Penicillin V may be adequate.

In *severe* infections the *secrets* are:

1. intravenous medication;
2. adequate doses and
3. long enough treatment.

It is also evident that if there is suppuration with abscess formation, or empyema, surgical drainage is a necessary factor.

Bacterial Meningitis

Again a knowledge of *likelihoods* will guide intelligent treatment until an etiologic diagnosis can be made. The newborn is most likely to have a meningitis due to coliform organisms. The older infant and young child (under five) most commonly has Hemophilus influenza B as the infecting organism. The older child is more likely to yield a meningococcus, as is frequently true in the adult, although the latter is not unlikely to have pneumococcal meningitis.

If there is evidence of ear infection, the most likely organisms are pneumococci or Hemophilus influenza, unless the ear complicated a strep throat or scarlet fever. If there is a leakage of spinal fluid through the orbit, the nose, or the ear, as the result of fracture in these areas, the most likely organism is the pneumococcus, but any variety *may* occur.

The infant (newborn) today would probably

be treated with ampicillin and kanamycin. All of the others would respond to ampicillin. Therefore, if the spinal fluid is cloudy, I would say start ampicillin at *once* and *then* wait for laboratory results to catch the occasional unusual organism. Again, all treatment in my opinion *must be intravenous*. Above 2 months old, 150 mg/kg/day is a good dose. If pneumococcal or meningococcal meningitis is proven, Penicillin G, I.V., is probably the treatment of choice—here I would use 15 million units daily for meningococcal, or 40 million units daily for pneumococcal in an adult.

If the patient with meningococcal or influenza meningitis is sensitive to penicillin, I would use tetracycline 40 mg/kg/day for a child or 2 gm/day for an adult, all intravenously. Chloramphenicol is also useful.

A further warning is, that in the beginning of treatment a loading dose of $\frac{1}{4}$ of the days dose ought to be given in the first two or three hours, and *then* the 24 hour schedule should be started.

There is every evidence today that the mortality in *single drug* treated patients is *lower* than that in multiple drug use, with the possible exception of newborns with coliform meningitis in whom ampicillin *plus* kanamycin *may* be superior.

Prophylaxis in epidemic meningitis should probably be limited to family or very intimate contacts. There is no evidence that hospital personnel are at risk.

Penicillin V-250 mg five times daily or erythromycin 500 mg four times daily for four days appear to prevent secondary cases in the family; I would continue to give sulfadiazine 2 gm daily for three days also.

As general principles then:

1. **Treat at once when purulent spinal fluid is found.**
2. **Give $\frac{1}{4}$ to one third of the daily calculated dose in 500 cc of saline in the first 2 or 3 hours. Then start daily schedule.**
3. **Always treat intravenously.**

For other forms of meningitis—

1. **For tuberculosis meningitis Streptomycin 1 gm IM daily for 3 to 6 months, followed by doses 3 times a week, and Isoniazid (INH) 10 mg/kg/day for one month, then 5-7 mg/kg/day for one year or more. Pyridoxine 100 mg/day may prevent neurologic toxicity.**
2. **Cryptococcal meningitis should be**

treated with Amphotericin B. The fungal infections are probably the *only ones in which intrathecal antibiotics should be used, since Amphotericin B penetrates the meninges very poorly.*

Any spinal fluid with a cell count under 500/ml should be examined by India ink preparation; order cultures for fungi and tuberculosis, and a VDRL and gold curve, in addition to the usual laboratory procedures.

Respiratory Tract Disease

The most important of the upper respiratory tract diseases requiring antibiotic therapy is probably streptococcal sore throat. Penicillin has always been considered the drug of choice, and needs to be continued for 10 days. If the patient is cooperative, Penicillin V by mouth, 250 mg 4 times daily is quite adequate. If there is lack of cooperation, it is probably safe to rely on a long acting injectable preparation like benzathine penicillin 1,200,000 units for adults. However, that at present more of the authorities are using erythromycin or erythromycin estolate not only in penicillin sensitive patients, but actually as the coming drug of choice.¹⁰ I have used this for years, and have had less treatment failures with it than with penicillin. In at least 4 of my penicillin failures, I have been able to demonstrate heavy growth of penicillinase producing staphylococci in the throats of the patients, in addition to the streptococci. We should remember that while sulfonamides work in prophylaxis of streptococcal throat infections, they are useless in treatment. Lincomycin is also quite useful.

Again in the viral sore throats, and mononucleosis, without streptococci present, patients do not do as well on antibiotic as without, nor do the antibiotics keep out bacterial invaders.

It is well to remember, too, that many strains of Group A hemolytic streptococci have now been found to be resistant to tetracycline, so this is no longer a suitable drug for use in these infections.

Diphtheria has already been touched upon and I would just remind you to look for it.

Penicillin is still the drug par excellence for pneumococcal lobar pneumonia, but if the patient is sensitive to penicillin, erythromycin, cephalothin, or lincomycin will do nicely. Some strains of pneumococci have now become resistant to tetracycline.

Streptococcal pneumonia is unusual, but the
(Continued on page 74)

The Story of Rheumatology in Chicago*

BY EUGENE F. TRAUT, M.D., F.A.C.P./CHICAGO

Chicago as a center of interest in rheumatic disease had its inception with Frank Billings. Following the invention of the microscope bacteria were being avidly sought and associated with disease. Billings was the center of a group of clinicians in the golden days of Rush Medical College. His intimate associates were Dr. Joseph Capps and Dr. Joseph Miller. At the Presbyterian Hospital were Dr. George Shambaugh, Sr., Dr. Edward Rosenow and Dr. Wilbur Post. Others on the staff at that time were Drs. Bertram Sippey, Grulee, Wilder, Rothstein, Bassoe and Arthur Dean Bevan.

Within walking distance, at the McCormick Institute of Infectious Diseases and the Durand Hospital, was Dr. Ludwig Hektoen with his co-workers, Drs. George Dick and Ruth Tunnicliff. Drs. Capps, Joe Miller and George Coleman of the Billings coterie were at St. Luke's Hospital. Closely allied at affiliated University of Chicago were Drs. Gideon Wells, Edwin Jordan and "Ajax" Carlson. The concept of focal infection arose from this Billings-led group. In that bacteriological era almost all types of joint disease were linked to infection.

At the end of World War I, Dr. Ralph Pemberton grouped Dr. Ralph Boots and Dr. McEwan of New York, Dr. Bauer of Boston and others to form the American Society for the Study of Rheumatic Disease, this to become a part of the Ligue Internationale Contre Rheumatisme based in Geneva, Switzerland as a part of the newly formed League of Nations.

Interest in rheumatic disease was given a great impetus by the energy and enthusiasm of Dr. Pemberton. Under the auspices of the Army he had utilized elaborate laboratory facilities to extensively study all phases of joint disease. As a part of this war effort Dr. Phillip Hench established an arthritic center in Arkansas. The hot springs there exude evil tasting sulphur water said to be radioactive and helpful in joint disease.

In 1920, I was invited by Dr. Joe Miller at McCormick Institute to meet a young man from New York, named Dr. Russell Cecil, to discuss organizing a rheumatism society as a Chicago branch of the American Rheumatism Association. Dr. Billings had allotted Joe Miller this task because he had authored an article on osteoarthritis in the *Illinois Medical Journal*.

Following Cecil's visit, Dr. Ernest Irons, representing the second generation of the Presbyterian Hospital-Rush Medical College dynasty, with Dr. Isadore Pilot, an associate of Dr. D. J. Davis and active in rheumatic disease at the new-born University of Illinois; Dr. David Markson, the founder of the arthritis clinic at Northwestern University; Dr. John Coulter, head of the department of physical therapy at St. Luke's Hospital, and I met in an auditorium at Cook County Hospital. We duly formed the Chicago Rheumatism Society and were enrolled as

charter members of The American Society for the Study of Rheumatic Disease. Subsequent meetings were held in the Lawson YMCA. Dr. Molander, a trainee of Dr. Coulter, joined us to represent Michael Reese Hospital. This group chose to remain small and select.

Crowe Method of Diagnosis

A prominent and enterprising internist had imported the teachings of Crowe from Charte-house Square, London, together with cultures of staphylococci isolated by Dr. Crowe from the skin of arthritics. In a large laboratory of a portentous suite on Michigan Avenue he sought agglutinins in the serum of patients. Reminiscent of current serological studies he added complement from the patient, giving a bad prognosis to those deficient in that antibody. Bacteria agglutinated by a patient's serum were used in making a specific vaccine. Perhaps we can forgive the enthusiasm shown by at least one of Chicago's leading orthopedists for embracing and acclaiming this oversimplified therapy and giving it his stamp of approval with recommendations to his fellow surgeons.

The changed surface tension of serum from patients with rheumatoid arthritis resulting in the agglutination of particulate matter such as bacteria, India ink and more recently bentonite, latex and blood corpuscles, even tanned erythrocytes from sheep to agglutinate, has been recognized for more than half a century. Such agglutinins and precipitins have been accorded perhaps more than deserved specificity. The Waaler-Rose and other tests, along with a certain amount of unjustified confidence, tend to replace bed-size expertise in categorizing patients with joint disease.

Ultimately the Crowe method of diagnosis and therapy became history. The Chicago Rheumatism Society added Drs. Edwin Jordan, Evan Barton and Dr. Irving Steck. Dr. Fahlstrom left Dr. Markson to develop an arthritis clinic at Mercy Hospital. Dr. Catherine Logan became the first woman in the Society. Dr. Willard Wood, in his introductory thesis, explained a way of detecting joint-damaging streptococci by determining their electric potentials. Bacteria selected in this way were used to make vaccines.

After the death of Dr. Emil Vrtiak, Drs. Stuppy, Wood, Barton and I cared for a clinic at Rush.

On my return from Europe in 1925, Dr. Barton and I introduced chrysotherapy to Chicago with its imposing iatrogenic morbidity. This led to an adverse opinion of gold as an additive to the other poisons used to treat arthritis and to its rejection by me as a costly, dangerous placebo. The use of gold in treatment has since been revived recognizing that its best results parallel its maximum reduction in dosage. In other words, the less gold used the better the results in the patients exposed to it.

At the behest of President Franklin Roosevelt, Dr. Paul Magnuson, an orthopedic surgeon at Northwestern University, organized nationally the Veterans' Facilities. He fostered a rheumatologic service at Hines. Subsequently Drs. Max Montgomery, Evan Barton and Herbert Rubinstein produced several excellent studies from Hines. They trained several well known rheumatologists, among them are Drs. Arnold Black and Robert Poske.



EUGENE F. TRAUT, M.D., F.A.C.P., is director of the Arthritis Clinic at the Cook County Hospital. He received his medical degree from Rush-Presbyterian-St. Luke's Medical College where he is Professor Emeritus.

The Whittier Process

At one of the meetings of the Chicago Rheumatism Society Dr. Reed of the department of physiology at the University of Illinois related his experiences with irradiated ergosterol, the so-called Whittier process. As a true scientist he had tried it on himself. He demonstrated to us the increased mobility of his osteoarthritic fingers. This benefit was attributed by him to the Vitamin D. This treatment was subsequently exploited in *Reader's Digest* by a professional medical columnist. Its sales soared. A well known orthopedist accepted money from the Whittier Foundation to establish a department at Northwestern University with Ertron Clinic emblazoned on its portals. Soon patients suffering from hypercalcemia after treatment with the huge doses of Vitamin D entered hospitals and deaths resulted. Ertron has since sunk into oblivion.

An investigator found the nails of patients with arthritis deficient in sulphur. This led to intravenous injections of sulphur, with reports of improvement in what Dr. Fishbein characterized as the tiresome 70%. One of Chicago's highest ranking rheumatologists characterized sulphur injections as errant quackery. He was unaware that it was the favorite treatment of his assistant, thus conforming to an acceptable definition of quackery: an activity practiced by someone else.

At the end of World War II, Drs. Steck, Rosenberg and I revived the Chicago Rheumatism Society. Dr. Ed Rosenberg became its first president, he had recently come from the Mayo Clinic to head a department for patients with rheumatic disease at Michael Reese Hospital.

Discovery of Cortisone

Arthritis erupted from the group of chronic, helpless diseases with the discovery of cortisone by Dr. Kendall. Dr. Philip Hench's easily reproduced benefits of corticosteroids revived worldwide interest in arthritis. Doctors flocked to the arthritis clinics. In Cook County Hospital's Clinic there were Drs. Allegretti, Passarelli, Thrift, Carstens and Clark. This talent led to an early account of activation of latent tuberculosis by steroids, a paper demonstrating placebo as effective treatment in 82% of all arthritics and studies showing placental extract to be efficient in inflammatory joint disease.

In moving pictures displayed before the Chicago Rheumatism Society, Dr. Rosenberg demonstrated the miraculous effects of Compound F cortisone.

Doctors formerly apathetic about the treatment of joint ailments were besieged by patients wanting to try the new miracle drugs. Physicians were thus spurred to acquaint themselves with this previously neglected disease. We conducted nationally advertised courses in joint disease under the auspices of the Cook County Hospital Postgraduate School.

Dr. Joseph Allegretti has directed a very active arthritis clinic at Grant Hospital. Dr. Steck, after his large clinic at the University of Illinois was dispersed, organized an arthritis clinic at St. Joseph's Hospital.

The University of Chicago had a succession of doctors working in rheumatology, usually as a secondary interest. Their affiliated La Rabida Hospital has achieved national recognition for fundamental studies under Drs. Gene Stollerman and Albert Dorfman. More recently the studies of Dr. Burt Grossman have greatly advanced knowledge of juvenile rheumatoid arthritis. Dr. Daniel McCarty, the emeritus editor of *Arthritis and Rheumatism*, has reorganized a department of rheumatology at the University of Chicago.

Dr. Frank Schmid, an indefatigable investigator, heads an ongoing department at Northwestern University and its associated hospitals.

The arthritis clinic at Cook County Hospital is the oldest and has the largest enrollment in Illinois. It should be understood that participation in the rheumatologic activities at Cook County Hospital is available to all clinicians and investigators from any institution in Cook County on an impartial basis.

Drs. Arnold Black and Paul Glickman conduct an arthritis clinic at Mt. Sinai Hospital. It is associated with the Chicago Medical School. Dr. Edward Rosenberg represents that school on the attending staff of Cook County Hospital.

Dr. Willard Wood of Presbyterian-St. Luke's Hospital has secured a large endowment for a chair in rheumatology in the recently reorganized Rush Medical College.

Orthopedic surgery, in my memory a recently recognized subspecialty, was first represented in Chicago by Colonel Ridlon, a student of Hugh Owen Thomas. Orthopedists, known as bone and joint specialists, succeeded less professional irregulars known in my youth as "bone-setters."

The use of open surgery of diseased joints has recently been very aggressive. Dr. John Boswick, Chief of the Hand Clinic of Cook County Hospital, has a large group of postgraduate students and trainees. Dr. Robert Ray, department head at the University of Illinois, has reconstructed joints damaged by arthritis. Other members of this society: Drs. Frank Howard, Jules Shapiro, Jerry Finder and Hartman, Chief of orthopedic surgery at Cook County Hospital, are using new surgical approaches in deformities of the hands and hip. Others about the Chicago vicinity are duplicating the operation made famous by George Halas.

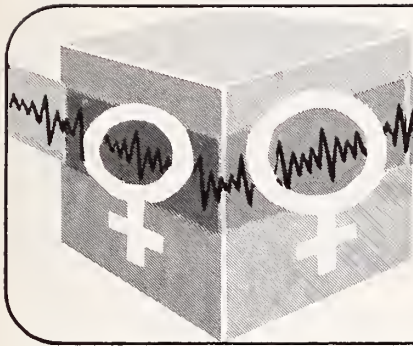
Work of the Arthritis Foundation

The Northern Illinois chapter of the Arthritis Foundation was organized in 1948 by laymen. Its avowed aims are to collect funds for furthering patient-care in joint disease, to inform the public on rheumatism, to further postgraduate study by physicians through annual seminars and to subsidize research. With the current leadership of Mr. Stanley Enlund it has currently been subscribing about \$100,000 annually to underwrite research in rheumatism and associated conditions in Chicago. It supports all arthritis clinics with annual gifts of \$1,000 each. The Illinois Chapter also sends thousands of dollars to the National Arthritis headquarters. These monies support the programs of trainees in rheumatologic centers, as well as research on or national scale. Large gifts come back to the University of Chicago and to La Rabida from the eastern based national chapter. Its loyal Women's Board has collected many thousands of dollars yearly to establish or support installations for clinical study at Northwestern University and physical therapy at St. Joseph's Hospital. The Women's Board built and installed the popular educational exhibit at the Museum of Science and Industry.

The annual or 2-yearly seminars are attended by 150 physicians. The annual public forums attract over 1,000 people, patients, relatives and friends. The Arthritis Foundation's activities are guided by a Medical and Scientific Committee of our fellow members.

About 10 years ago departments of medicine in most schools and other institutions decided to deemphasize rheumatology as a specialty. Arthritis clinics were phased

(Continued on page 74)



pulse... of the doctor's wife

MRS. ROSEANNE K. FRANK, *Editor*

Profile of Mrs. Willard C. Scrivner

Mrs. Willard C. (Ruth) Scrivner is . . . the new President of the Woman's Auxiliary to the American Medical Association; the First Lady of the Illinois State Medical Society; a civic leader; a Registered Nurse and former nursing instructor; a mother of two sons; a grandmother of four and the wife of the ISMS President with whom she teams up in a strong commitment for organized medicine.

At the annual meeting of the WA/AMA held in New York last month, Mrs. Scrivner of Belleville, was installed as the new president. Some of the goals and objectives she has established for her year of office are: 1) strength and effectiveness with a purpose; 2) unity; 3) aid to the medical profession in its objectives and working for improvement in Quality of Life through better health care for every American. Concerns on which she plans to concentrate include: 1) battered child syndrome; 2) proper care for the aging; 3) safety; 4) children; 5) effective legislative action; 6) increased membership; and 7) development of excellent public relations at every level.

In 1935, Mrs. Scrivner joined the Woman's Auxiliary to the St. Clair County Medical Society. Due to her full-time position at Barnes Hospital, St. Louis, her participation was limited for the first ten years. Later, during 1952-53, she served as president of the county auxiliary.

When Mrs. Harlan English served as President of WA/ISMS, she held workshops which encouraged Mrs. Scrivner to become more interested in auxiliary work. Mrs. Scrivner then filled an unexpired term as 10th District Councilor and held this position from 1956-1961. In 1961, she was elected Vice President of the WA/ISMS, with the Benevolence Fund as her principal area of concentration. For two con-



Mrs. Willard C. (Ruth) Scrivner

secutive years she served the state as Vice-President in charge of program planning. Under the Presidency of Mrs. Mathew Uznanski, 1963-64, Mrs. Scrivner served as President-Elect in charge of membership.

As President of WA/ISMS, 1964-1965, Mrs. Scrivner maintained the state theme of "Health and Freedom through Love and Service." One of her goals and objectives then was: "to make the dream of Health and Freedom a reality



Mrs. Willard C. Scrivner (third from the left), the new WA/AMA President, gathers with her husband (right) and Dr. and Mrs. Robert Beckley during the annual meeting of the Woman's Auxiliary to the American Medical Association held in New York last month. Mrs. Beckley is the immediate Past President of WA/AMA.

by demonstrating the good that may be derived by love for one's fellow man through serving him."

Some of the most rewarding outcomes of her year as the State President were: 1) development of closer rapport with the State Medical Society; 2) greater cohesiveness between county and state auxiliaries; 3) increased membership and addition of one new county auxiliary; and 4) a "workshop team" that visited councilor districts. St. Clair County and was a member of its Board during 1961-1969.

Then, in 1965, she served as a WA/ISMS Director. The following two years she served as Chairman of Revision and Resolutions.

Her activities on the national level began in 1965 when she worked as North Central Regional Vice President for two years. She was encouraged by Mrs. Rodney C. Stolz, Past National President and Vice President of North Central Region, to pursue a leadership role in WA/AMA. Between 1967 and 1970, Mrs. Scrivner was the Director and Chairman of Home Centered Health Care on the national level. The following two years she was elected First Vice President of WA/AMA; then, in 1972, she was selected as President-Elect, under the Presidency of Mrs. Robert Beckley.

In addition to her busy life with the Woman's Auxiliary, Mrs. Scrivner has maintained an active role in civic affairs. She has participated in Red Cross activities for more than 25 years, and served on the Board of Directors of the

American Red Cross of St. Clair County for seven years.

She was the first woman to be elected to the Signal Hill School District #180 School Board, where she served for six years. Mrs. Scrivner has also been a Board member and Vice President of the Steering Committee of Family Service Agency of Southwestern Illinois. She assisted in activating the Home Care Association of the county auxiliary.

Mrs. Scrivner was appointed by Governor William Statton of Illinois as an Illinois delegate to the White House Conference on Aging in 1961. She testified at a public hearing on Medicare held in St. Louis that year before Senators Edward Long of Missouri and Senator Everett Dirksen of Illinois.

In 1971, Mrs. Scrivner again was appointed to serve at the White House Conference on Aging. Under the Governorship of Richard Ogilvie, Mrs. Scrivner served on the Illinois' Committee on Aging. Since 1969, until presently, she has been board member of the Child Care Association of Illinois.

Because both Mrs. Scrivner and her husband maintain leadership roles in organized medicine this year, they do travel together for state events. In their commitment to organized medicine they endeavor to work as a team. Even though their active lives permit only rare weekends for leisure, Mrs. Scrivner feels that their involvement with ISMS and AMA make a very interesting and rewarding life.



report

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Obituaries

***Binswanger, Herbert F.**, Chicago, died May 17, at the age of 74.

****Channon, Benjamin Z.**, Des Plaines, died May 10, at the age of 88. He had been a surgeon for 52 years until he retired in 1966. Dr. Channon was a member of the first class to graduate from the University of Illinois Medical School in 1912.

***Clarke, T. Howard**, Chicago died at the age of 63 on May 10. He was elected president of the Illinois division of the American Cancer Society in 1970. He was a professor of surgery at the University of Illinois and until 1971 a professor of surgery at Northwestern University. Dr. Clarke was Medical Director of the Illinois Masonic Center.

***Fitzgerald, James Robert**, died May 15, at the age of 62. Before his retirement in 1972, he was Chairman of the Ophthalmology Department at Loyola University Stritch School of Medicine, Maywood.

****Yngve, Joranson**, Chicago, died at the age of 85 on April 17. He practiced medicine for more than 50 years.

****Kaufmann, Gustav L.**, Chicago, died May 24. Dr. Kaufmann, practiced medicine for more than 50 years.

***Holland, W. W.**, Macomb, died at the age of 76.

***Madura, James Walter**, Chicago, died May 19, at the age of 59.

****Pagano, Ralph, M.D.**, Chicago, died April 11, at the age of 95. He had practiced medicine for more than 50 years.

***Scully, George F.**, Chicago, died May 12 at the age of 52. He had been a staff physician at Little Company of Mary since 1947. He also had been the head of the medical department of Borg-Warner Ingersol Steel Co. for 18 years.

***Tosney, Harold J.**, died May 8, at the age of 70.

****Underhill, Marshall S.**, died May 27. He had practiced medicine for more than 50 years.

****Zalatoris, Peter Z.**, Chicago, died May 4, at the age of 87.

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Studies of Histoplasmosis

(Continued from page 33)

of infection within the endemic region of the United States. This supports the theory that an endemic region is not a true belt of infection but rather a multiplicity of various-sized foci placed on a background of uncontaminated soil.⁹ Endemicity seems to mean numerous, closely spaced foci as opposed to a few, widely scattered ones. If so, we must learn more about factors affecting dispersal of the spores, dilution, and infective doses, since a disease reservoir which is limited essentially to fixed foci is dependent upon the host visiting the source or being infected by airborne dissemination of spores which could travel a mile or so. Such being the case, a complete surveillance program which includes careful plotting of all movements of the case during the incubation period, theoretically could in time disclose all major foci of infection.

Limiting human movements in such areas when environmental conditions are propitious for dispersal of the fungus could reduce the number of infections; but airborne dissemination of spores will infect some persons at home or on way to school, etc. Final solution of the problem must await better techniques of starling control. ◀

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Pediatric Perplexities

(Continued from page 35)

basis.

The recommended dose is 0.01 mg/kg administered intravenously or intramuscularly. Naloxone has an distinct advantage over the previous narcotic antagonists; namely, it does not cause respiratory depression in the absence of narcotic overdose.^{3,5} ◀

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EKG of the Month

(Continued from page 63)

Answers: 1. e 2. d.

Pulmonary embolism may produce acute cor pulmonale. Although there are no pathognomonic electrocardiographic changes, following are suggestive of the diagnosis: 1) sinus tachycardia or atrial arrhythmias; 2) shift of mean electrical QRS axis rightward; 3) transcendent complete or incomplete RBBB; 4) ST-T wave changes in right precordial leads; 5) clockwise rotation of the heart with appearance of rS pattern in most or all chest leads; and 6) P-pulmonale. ◀

View Box

(Continued from page 36)

Diagnosis: *Congenital solitary kidney*—This is an interesting patient because of the findings other than the urinary tract. A careful inspection demonstrates that the growth centers for the superior iliac crests have not fused in a patient 35 years of age. This represents a patient with known gonadal dysgenesis. These patients are phenotypic females characterized by sexual infantilism, congenital webbed neck and cubitus valgus. These patients have female external genitalia, uteri and fallopian tubes, but no true ovary is present.

Some of the multiple skeletal abnormalities which are associated with gonadal dysgenesis are: fusion of bones in the hands, and feet, tibial exostoses, medial projection and enlargement of metaphyseal portion of the tibial condyle. A relatively shortened fourth metacarpal occurs in a high percentage of cases. A high percentage of these patients have abnormal pyelograms. The most common malformation is malrotation of the kidneys, horseshoe kidney, and solitary kidney. In this case retrograde examination revealed the presence of a single ureteral orifice and an angiogram revealed solitary renal artery on the left side. ◀

The Story of Rheumatology in Chicago

(Continued from page 68)

out. Patients with rheumatic disease were consigned to and treated by non-discriminating generalists, internists, residents and internes working in departments of general medicine. We are now witnessing a reversal of this attitude.

The American Board of Internal Medicine has given rheumatology subspecialty status. The Board will examine applicants to identify qualified, formally prepared physicians as specialists in rheumatic disease. Correspondingly, deans and heads of institutional departments of medicine are hastening to reorganize arthritis clinics staffed by physicians possessing interest and expertise in this field. Let us hope that the pendulum will not swing too far; that this subspecialization will not take us back to joint specialists unable to see the forest for the trees; or failure to treat the rheumatic patient as a sick person, or failure to recognize that disease expressing itself in the joints can be importantly connected with the whole body. ◀

The Abuse and Use of Antibiotics

(Continued from page 66)

same treatment applies.

In staphylococcal pneumonia, it is probably best to start with a penicillinase resistant penicillin, until sensitivity is established, or to use cephalothin or vancomycin in some cases.

Hemophilus influenza is not rare in young patients, and can be treated well with ampicillin, or in the sensitive patient, with erythromycin or tetracycline.

For E. coli pneumonia, kanamycin is the drug of choice and for pseudomonas use polymyxin B.

Friedlander's pneumonia responds to kanamycin, tetracycline or chloramphenicol.

There is now good evidence that tetracycline or erythromycin will shorten the course, and hasten the radiologic clearing in Mycoplasma Pneumoniae pneumonia (Eaton agent pneumonia).

Conclusions

In hospitals with adequate laboratory facilities, a very useful guide is a table of antimicrobial resistance patterns for the individual hospital. This can help in selection of antimicrobial therapy.

In summary, I would urge you to:

1. Get adequate history.
2. Examine the patient.
3. Get adequate specimens for culture and smear.
4. Begin appropriate therapy, with adequate doses.
5. Wait for culture results if there is no emergency.

I have not tried to outline absolute regimens of treatment for several reasons. First, there are good sources for you to consult. Second, what I would recommend may be out-dated next month. In conclusion, I emphasize the following:

1. Warn about the promiscuous use of antimicrobials.

2. Warn about the use of those antibiotics that actually threaten life, or serious consequences, where the danger of the infection itself does not warrant the choice. (In our Student Health Service, no one gets oral or injection penicillin without a skin test.)

3. Suggest that you watch the current literature *constantly* for warnings of reactions, for the development of resistance, and for the development of new, adequately researched, antibiotics and chemotherapeutic remedies. ◀

References

A complete bibliography for "The Use and Abuse of Antibiotic and Chemotherapeutic Remedies" is available from the *Illinois Medical Journal*, 360 N. Michigan Ave., 60601.

Traumatic Rupture of Thoracic Aorta

(continued from page 57)

Summary

A case of an 18-year-old male who was involved in an automobile accident and sustained traumatic rupture of the aorta has been presented. No comprehensive summary of the diagnostic techniques nor the techniques of the surgical treatment has been attempted. It is pointed out, however, that a high degree of suspicion is necessary in such cases and such patients should be immediately referred to areas where diagnosis can be confirmed by aortography if there is any reason at all to suspect a ruptured aorta.

Addendum

Two additional cases of acute traumatic rupture of the aorta have been successfully repaired using a similar technique. ◀

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Disability Insurance Under Social Security

BY HARRY E. GRANT, M.D. CHIEF MEDICAL CONSULTANT

FEDERAL DISABILITY PROGRAM ILLINOIS STATE AGENCY

WHENEVER A PHYSICIAN is asked to furnish a medical report in connection with a patient's claim for Social Security Disability Benefits, it's a reminder that Social Security is not just for the retired—it also provides important financial help for people who cannot work because of a serious illness or injury. Currently, over 3 million men, women and children receive Social Security Disability checks every month because someone in the family, usually the breadwinner, is disabled. Their payments total almost \$5 billion a year. In addition, more than 76 million working men and women are insured for disability benefits as a result of their earnings, wages or self-employment, under Social Security. Beginning July 1, 1973, full Medicare protection will be extended to persons under age 65 who for at least 24 consecutive months have been receiving monthly Benefits because they are disabled.

A person under 65 can receive monthly disability benefits if he has a physical or mental impairment severe enough to prevent him from doing any substantial gainful work for a year or longer. Benefit amounts based upon a person's earnings under Social Security range from \$84.50 to \$345.50 a month for the disabled worker alone, and the maximum monthly benefit for a disabled worker with a family is \$620.40.

From a Small Beginning

The original Social Security Act of 1935 provided benefits only for the retired worker. It was not until 1954 when the disability "freeze" provision was added that the law gave some protection to the disabled worker. Under the freeze, years when a worker earned little or nothing because of disability were not counted against him later in deciding if he was eligible for retirement benefits, or in figuring his retirement benefit amount. To be eligible for the freeze, the worker had to have a disability that was expected to be of "long-continued and indefinite" duration.

Two years later, monthly cash benefits were provided for disabled workers aged 50 to 64, and for the disabled adult sons and daughters

of retired or deceased workers, if the son or daughter had been continuously disabled since childhood.

Over the years, the Program has been further improved. The minimum age limit of 50 for payment of benefits to disabled workers was eliminated; "long-continued and indefinite" duration was changed so that an insured worker could be eligible if his disability had lasted or could be expected to last for at least 12 months; fewer years of covered employment were required for a young worker to be insured for disability; and benefits were provided for disabled widows (between ages 50 and 60) of covered wage earners. The latest change is, of course, Medicare protection for disabled persons under 65.

Who Can Get Benefits?

Social Security Disability Benefits can now be paid to:

- *A disabled worker* under 65 and his family, if he has worked under Social Security for a certain length of time, ordinarily 5 of the 10 years preceding the onset of disability. (Special provisions apply to workers disabled by blindness allowing them to qualify with even less work under the Program). For the worker who becomes disabled before he reaches 31, the work requirement ranges down with age to as little as 1½ years.
- *A person continuously disabled since childhood* (before age 22), if one of his parents (in some cases a grandparent) who is covered under Social Security retires, becomes disabled, or dies. The mother of the disabled son or daughter may also receive monthly benefits as long as she has the child in her care.
- *A disabled widow* 50 or over, if her late husband was covered under Social Security, and if she meets the specified level of medical severity. This also applies to disabled dependent widowers and certain disabled surviving divorced wives.

Reporting Medical Evidence

When a patient applies for benefits, he is asked to submit medical evidence to support his claim. This evidence usually consists of data from the records of his treating physician, clinic or other medical source. Our experience with the Disability Program in Illinois indicates that in about three out of five cases no further medical development is needed because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

This information may be requested on the patient's behalf by a Social Security office, or, more often, by the Federal Disability Program, Illinois State Agency. This is the full name of the Agency in Springfield that evaluates Social Security Disability claims for Illinois residents. Like other States Agencies throughout the country that work with Social Security in the Disability Insurance Program, the Illinois Agency in Springfield includes both physicians, numbering 31 of various specialties, and trained disability examiners on its professional staff.

With the assistance of our staff of reviewing physicians, we endeavor to make these requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the busy physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information available.

The evaluating physician in Springfield never sees the patient. He depends heavily on information supplied by the physician or clinic to assess the severity by the applicant's impairment, its expected duration and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the quality of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient for us to evaluate the claim and make a decision.

For example, if the patient experienced a myocardial infarction, we would look to the report submitted by the treating source for such information as date of occurrence, place and duration of the hospitalization, as well as results of X-rays, electrocardiograms, and other laboratory studies. Serial ECG tracings should, whenever possible, accompany the report so that our staff of physicians may also have the benefit of reviewing this essential documentation. Equally important is the medical history, including onset of chest discomfort, relationship to effort, intensity, location, radiation, regularity,

and to what extent relief is obtained by rest or medication.

If a report does not contain all the findings necessary to make a proper decision, one of our reviewing physicians may recontact the medical source. However, the additional time required may delay the patient's claim and can add up to a significant additional Program expense. You can help speed the decision on your patient's claim by reporting all relevant data about his medical condition as promptly as possible.

Establishing the onset date of disability, often a key factor in determining the beginning date and amount of the claimant's benefits, is frequently difficult. Therefore, it is extremely helpful if the reporting physician includes the date of each important fact or finding. To save time, he may enclose photocopies of pertinent sections of the patient's chart or of hospital or consultant's reports.

Criteria for Evaluating Disability

In making disability determinations, our Agency uses medical criteria developed by the Social Security Administration to insure uniform evaluation of all applicants no matter where they live, and to help simplify and speed the decision process. These criteria were worked out with the aid of practicing physicians, major medical organizations and SSA's Medical Advisory Committee.

Generally, a claimant who is not working can meet the Social Security definition of disability if he has an impairment or combination of impairments that are the same as, or medically equivalent to, any set of findings in the criteria. (This is the only way the *widow 50 or over* can qualify for disability benefits). However, for *all other claimants* whose impairments fall short of this test, such factors as age, education, and work experience added to the functional limitations imposed by the medical condition are taken into consideration in making the disability decision.

The complete criteria, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook describes impairments in terms of specific symptoms, signs and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer.

The handbook may be obtained from the Federal Disability Program, Box 3082, Springfield, Illinois, 62708. We also welcome any inquiries from physicians who wish to know more about the Social Security Disability Program and its policies and procedures. ◀

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (10)

ALEDO: Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Forth Street, Aledo, 61231, 309-582-5156. (9)

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington 61701, 309-828-6051. (10)

BLOOMINGTON-NORMAL: Population 80,000. General Practitioner in 3 man partnership—25 year establishment. Complete office, Lab., & X-ray facilities. Salary first year and full partnership thereafter. Three hospitals available, but only one used. Housing available—rent or buy. 90 miles from Chicago Loop. Contact: Homer C. Lyman, M.D., 5 Citizens Square, Normal, 309-452-1151. (8)

CARLINVILLE: G.P., I.M., Ped., OB-GYN. Population 5,700. Mid-way between St. Louis and Springfield. Serves 30-mile trading area of 50,000 population. Newly built physicians building adjacent to hospital. Modern office space for doctors. Modern 68-bed hospital fully equipped and staffed. Opportunity for building large practice. We need doctors. Contact: James Rives, Carlerville Area Hospital, Carlerville, 217-854-3141. (7)

CHICAGO: Field Clinic has opening for an Internist with a specialty either in allergies, rheumatology, or gastroenterology. Salary is open. The Field Clinic is one block from Ravenswood Hospital, which is a 400 bed medical center. Contact: Kenneth Hatfield, M.D., 4600 N. Ravenswood Ave., Chicago 60640. 312-275-7700. (8)

CHICAGO: Local Medical Examiner, half or fulltime, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, G.P., or surgeon. Salary negotiable, excellent benefits. Call 431-4671 or write Room 708, 122 South Michigan, Chicago, 60603 for information. (9)

CHICAGO: Opening in welfare clinic, south side; no hospital work. Guaranteed salary. Good opportunity to work into a part-ownership. Contact: Robert C. Parro, Chicago Medical Center, Inc., 657 W. 79th St., Chicago, 60620, 312-994-0100. (11)

CHICAGO: The Cancer Prevention Center, a multi-phasic health screening facility, seeks internists, surgeons, gynecologists for its comprehensive health examinations. Employment is part time. Interested physicians are invited to visit and apply. Please contact the office of Angelo P. Creticos, M.D., 33 W. Huron, Chicago, 60610, 312-944-4371. (11)

DANVILLE: Population 45,000; Drawing area more than 100,000. Primary need in General Practice-Family Physician, however many specialties also required. Excellent hospital facilities; many specialties well represented. Fine community, affiliation with the University of Illinois Medical School available. Office space available. Contact: W. N. McCormack, M.D., 812 Box 144, Evansville, 62242, 618-853-2629. (9)

N. Logan Avenue, Danville, 61832, 217-443-5362. (11)

DU QUOIN: Population 7,000, 75 miles South of St. Louis and 20 miles north of Southern Illinois University. 1 Surgeon and 1 General Practitioner & OB GYN. Excellent opportunity for both to build lucrative practice. Brand new hospital with all new equipment and facilities. Present hospital board and staff will support. Office spaces can be made available. Area has good recreational facilities, good school and shopping areas. Contact W. M. Thornburg, M. D., 111 W. Main St., Du Quoin 62832 618-542-2137. (9)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors needs. Also, we have financial assistance available. Contact: Jim Biethman,

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D. 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (9)

FREEPORT—Population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multi-specialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include \$50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALENA: Pop. 4,000. Family/General Practitioner needed to join three other FPs. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 80,000. Historical community offers very good school systems, numerous churches, and outstanding recreational facilities. Contact: Wilbur E. Johnson, M.D., 300 Summit Street, Galena, 61036, 815-777-0900. (11)

GENESE0: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (9)

HARRISBURG: 4 General Practitioners, Cardiologist, OB-GYN and Ophthalmologist wanted. Population of 10,000. Modern hospital to practice in. Please contact Carl L. England, Jr., Administrator, Doctors Hospital, Harrisburg, 618-253-7671. (11)

HARVARD: Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing area and financially sound. Sixty five miles northwest of Chicago, thirty miles east of Rockford. Community committee, including present doctors. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033, 815-943-5261. (9)

HERRIN: Int., G.P., ENT, Anesth. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (11)

LAKE FOREST: Internists, certified or eligible, needed to practice in fine north shore community, with excellent earning potential. University appointment desirable. Excellent hospital with all specialist medical staff. Contact: Steven L. Seiler, Lake Forest Hospital, Lake Forest, 60045, 312-234-5600. (9)

MACOMB: G.P., Int., -Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (9)

MACON: Thriving community of 1600. Five of seven nearby towns without resident physician. Adequate unfurnished building available. Assistance given to become established. Located 8 miles south of Decatur (two first-class hospitals). Excellent schools. Five churches. Contact: Olive Johns, 250 W. Ruby St., Macon, 62544, 217-764-3483. (11)

MINONK: Population 2,500. Serving a patient area of over 10,000. Opening in new Medical Clinic, Inc. Twenty-five miles from two Universities in Bloomington and in Peoria. Schools, churches and facilities nearby. Contact: H. T. Barrett, M.D., 200 E. Sixth St., Minonk, 61760, 309-432-2525. (10)

MONMOUTH: Services area population 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurcholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (9)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (9)

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265. (11)

PANA: We need 2 physicians to practice general medicine in a friendly active community of 6,500. 45 minutes from Springfield or Decatur, 1½ hours from St. Louis. Economy is farming and light industry. 5 schools, 16 churches, parks, clubs, lakes, etc. Contact John Luff, Pana Hospital, Pana, 62557, 217-562-2131. (9)

PLYMOUTH: Population 800 plus large rural drawing area. Ten-year-old clinic & office building (large) available. Two closest hospitals 18 miles. Large Illinois University 18 miles. Golf course, hunting, fishing, etc. close by. Grade and high school in town. Contact: Ken Smith, Box 21, Plymouth, 62367, 309-458-6241. (9)

PONTIAC: Population 11,000, trade area 50,000. 100 miles south of Chicago on Route 66. Wanted: family practitioners. Office space available adjacent to hospital. Contact: Dale Budde, St. James Hospital, 610 East Water St., Pontiac, 61764 or call collect: 815-844-5134. (9)

RIDGE FARM: Population 1,015. Seventeen miles south of Danville. No physician at present. Complete office facilities. Financial assistance available if needed. Contact: Nolin Weathers, 207 E. North St., Ridge Farm 61870, 217-247-2265. (8)

ROSICLARE: G.P., Ped. Hospital serves 2 counties—approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (9)

STREATOR: Physician to join three other G.P.'s in general practice group. All privileges available in beautiful new hospital to qualified M.D. Modern clinic building, well staffed. Generous salary to start, full partnership available after trial period. Rotating office hours, night and week-ends off, vacation, etc. Contact: George Powers Jr., M.D. and James E. Gottmoller, M.D., 301 S. Bloomington Street, Streator, 61364, 815-672-2133. (10)

WASHINGTON: Population 10,000 plus, need family physician; financial assistance available, office of doctor, recently retiring, with some equipment available. Ten minutes from Peoria. All recreational facilities available in or near Washington. 1 year free use of car provided, 6 mo. rent free residence available. Contact: Dean R. Essig, 139 Washington Square, Washington, 61571. (7)

WATSEKA: Population 5,800. General Practitioners needed. Clinic or single opportunity available. 16 physicians at present. Eighty-five miles from Chicago. New facilities, 114-bed hospital. Specialist available. Contact: Administrator or Chief of Staff, Iroquois Memorial Hospital, 200 Fairman Street, Watseka, 60970, 815-432-5201. (7)

WENONA: General Practice Opening. Population 1,200. Several nearby communities without physicians. Only physician wanting to retire soon because of health. 15 miles from new St. Mary's Hospital at Streator. Office space and financial assistance available. Excellent schools. Contact: William Gilman, M.D., 407 1st North St., Wenona, 61377, 815-853-4511. (10)

WEST FRANKFORT: GP to take over well established practice in scenic Southern Illinois. Enjoy serenity of

small town living, population 9,000, in center of rapidly expanding recreational facilities. Hospital in town. No investment needed. Call or write: C. E. Ahlm, M.D., 107 S. Van Buren, West Frankfort, 62896, 618-932-5015. (10)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Population 11,000, close to Chicago, growing community, complete office facilities with laboratory and X-ray, new 150 bed hospital well equipped. Need internist and pediatrician. Contact: J. Tambone, Northwest Clinic S. C., 102 E. South St., Woodstock, 60098. 815-338-2345. (8)

WOODSTOCK: Population 15,000. Two man corporation desires Generalist or Internist. Complete office facilities. 130-bed general hospital. Approximately 60 miles from Chicago. Salary open depending on qualification and experience, with partnership in 2 years if agreeable. Contact Dr. H. A. Stahlecker, Jr., & Dr. P. D. Exconde, 666 W. Jackson Street, Woodstock 60098, 815-338-2210 Collect. (9)

WONDER LAKE: Associate Wanted. Residential oasis on privately owned 12-mile shoreline lake. Summer-winter sports. Good schools, many churches. 55 miles from Chicago, Milwaukee, Rockford. Two local hospitals. Complete facilities for Family Practice. Contact: S. L. Ruggero, M.D. ABFP, Box 137, Wonder Lake, 60097. 815-653-2131. (8)

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Abstracts of the Board of Trustees

(Continued from page 17)

in New York. The residents' expenses will be paid from the fund created by the House of Delegates to increase liaison with physicians in training; medical students have been attending AMA meetings for several years with the expenses budgeted.

Drugs and Therapeutics

The Board agreed to voice its objections to newspaper stories alleging that physician carelessness is responsible for prescription blanks falling into the hands of drug addicts. The rebuttal will be publicized in "Action Report."

Legislation

The Board approved the following recommendations of the Governmental Affairs Council, that:

1. Temporarily no position be taken on HB-724, the Developmental Disabilities Agency.

2. SB-955, New Super Department of Health and Social Services, be opposed.

3. ISMS support HB-738, which amends the present Coronor's Law.

4. ISMS aggressively oppose HB-978 and SB-966, which would prohibit physicians from owning pharmacies or dispensing drugs.

5. HB-979, which prohibits fee splitting or kickbacks by pharmacies to hospitals, doctors, etc., should be opposed unless amended to eliminate the provision which allows pharmacists and doctors to form medical service corporations.

6. ISMS oppose HB-1018 and 1078, although both have been killed in committee. The former would allow interest to be paid on medical bills left unpaid by a deceased person; the second would require fee schedules for licensed health care professions.

7. HB-1319 be supported. This bill requires certain safety measures for new health care facility construction.

8. HB-1412, expansion of the Nursing Practice Act, be opposed unless appropriately amended.

9. ISMS vigorously oppose HB-1414 which would create a Health Division in the Department of Registration and Education, expand the Medical Examining Committee by adding one consumer and one health-related professional and create a 21-member Health Care Professions Board, which would include only one physician with representatives of 20 miscellaneous professions. The Board reacted so strongly to this bill that it authorized expenditure of such staff time and effort as will be needed to defeat this bill by contacting doctors and urging them to exert their influence on their own legislators. Toward this end, the Board directed that telegrams voicing opposition to this bill be sent to appropriate legislators over the name of each board member.

10. HB-1419, which provides for hospital interdisciplinary manpower utilization committees, be opposed unless the section calling for an interdisciplinary manpower utilization committee is amended out of the bill.

11. HB-1427 (freedom of choice for the consumer) and 1474 (reestablishing of the Health Care Licensure Commission) be opposed.

12. HB-477, which amended the Cook County Hospital Governing Commission Act, be supported as amended.

13. SB-477, which would license electrologists, be opposed; but the Board should designate a particular committee to work with reputable electrologists in Illinois to develop a bill for the 1974 session of the General Assembly.

14. SB-792, amending the Renal Diseases Act, be supported as amended.

15. SB-849, a bill defining death, be opposed although it has been tabled for this session of the legislature.

16. No position be taken on SB-903, which provides for a uniform accounting system for Illinois hospitals.

17. SB-1099, clarifying the Illinois Nurses Act, be supported.

18. The subject matter of SB-582 and SB-1071 be referred to the Executive Committee with directions to consult with appropriate legislators on the matter of revising the qualifications for directors of the Illinois Departments of Public Aid and Public Health.

19. SB-515A be opposed until funding mechanisms have been developed for licensing ambulances and invalid coaches.

20. SB-927, which is enabling legislation to allow ambulatory surgical treatment centers to receive payment from insurance companies, be supported.

21. SB-926 be opposed because in its present form it would allow chiropractors, psychologists, optometrists, and acupuncturists to become members of medical service boards and to be paid directly under separate contracts for medical services. The Board will work with Blue Cross-Blue Shield in developing better legislation to expand its boards.

ISMS is to convene a meeting with representatives of ISMS, the Illinois Hospital Association, the Directors of the Comprehensive Health Planning "A" agency, CHP "B" agencies and other interested persons to come to an agreement on Certificate of Need.

The Board will cooperate to the fullest extent in implementing HR-265, which calls upon ISMS and the Illinois Pharmaceutical Association to deal with the problem of expiration dates on drug container labels.

ISMS will request the Directors of the Department of Registration and Education and the Department of Insurance to explore the question of Medivets (Viet Nam veterans trained as military medics) performing insurance physicals.

Referred to the Governmental Affairs Council was a series of recommendations from the Council on Mental Health and Addiction:

1. Support for HB-29 (making explicit the confidentiality of patient records).

2. Opposition to HB-825-826 (licensing marriage counselors).

3. Opposition to HB-465 (make incurability of mental illness grounds for divorce), unless amended to extend diagnosis time.

4. Support for HB-496 and HB-982 (eliminates requirement of triplicate prescription forms for controlled substances).

5. Support for HB-629 (includes alcoholism treatment in health insurance policies).

6. Support for HB-631 as amended (uniform alcoholism and intoxication treatment).

7. Support for a series of bills introduced by Sen. Esther Saperstein (SB-824-827 and 829, 830 and 832A) to upgrade patient care and facilities in state mental institutions. Some amendments are recommended for these bills, which are based on investigations of the Illinois Mental Health Commission. No position was recommended for one of the series—SB-828.

8. Opposition to SB-337 (testing of individuals for drug abuse).

9. Support for SB-881 (mental illness coverage option in health insurance policies).

The Board also agreed to offer to the Illinois Department of Mental Health the assistance of the Council on Mental Health in any contemplated revision of the Mental Health Code.

The Board referred the following recommendations of the Council on Environmental and Community Health to the Governmental Affairs Council:

1. HB-518, licensure of hearing aid fitters and dealers—be supported with ISMS amendments.

2. SB-1049 and 1050, regulating conditions under which abortions may be performed—be supported.

3. HB-1566, permitting chiropractors to perform school physicals—be opposed.

4. HB-1679, permitting registered nurses to treat colds—be opposed.
5. HB-1136 and 1191, changing requirements for School Employees' TB examinations—be opposed.
6. HB-725A, establishing regional perinatal centers—be referred to the Executive Committee with power to act.
7. HB-1910, full utilization of TB sanitarium beds for research and general care—be supported.

Contributions

The Board approved the contribution of \$100 to each of three agencies—the Institute for Sex Education, the Chicago Alliance for VD Awareness, and the Illinois Interagency Council on Smoking and Allied Diseases.

Nutrition Conference

The Board approved a recommendation that ISMS again support the Conference on Nutrition in Medicine, which it has co-sponsored for more than 15 years. ◀

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IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multispecialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

PART-TIME LOCUM in Beautiful Suburban Clinic. Hours arranged to suit. General and E.R. Practice. Liberal Hourly Salary. Write: G. A. Caress, 2320 W. High Street, Blue Island, Illinois 60406, or Call (312) 388-5500.

GASTROENTEROLOGIST WANTED for beautiful multi-specialty clinic in south suburbs of Chicago. Must be licensed in Illinois. Write: Mr. G. A. Caress, 2320 W. High St., Blue Island, Ill. 60406 or Call: (312) 388-5500.

INDUSTRIAL PHYSICIAN: Unusual opportunity for doctor interested in Industrial Medicine and performing minor traumatic surgery; clinic located southwest side of Chicago. Starting salary \$35,000. Doctor can only go up from this base. Write P.O. Box No. 812, c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

A BETTER PLACE TO PRACTICE MEDICINE—For those who would prefer to live in a warmer climate, avoid the big city school, traffic and practice problems; contact this multi-specialty group, located in a city of 100,000 people in North Central Texas. Specialists in Internal Medicine, Family Practice, Pediatrics, General and Orthopedic Surgery are needed to complement the current staff of twenty-one full time physicians. Contact: Wichita Falls Clinic-Hospital, 1300 Eighth, Wichita Falls, Texas 76301.

WANTED: PHYSICIANS, SPECIALISTS OR GENERALISTS, who want to discover Ozaukee County, Wisconsin. A beautiful blend, rural agricultural with many cities and villages growing and progressing but still preserving an Early American charm. This prime recreation area bordering Lake Michigan has a modern progressive hospital at Port Washington serving the population of 55,000 but short the necessary link—Physicians. Contact George Seidenstricker, St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone: 414-284-5511.

DIRECTOR OF MEDICAL EDUCATION—Large, voluntary, general hospital located in Chicago, offers an excellent opportunity for a full time Director of Medical Education. Prefer a physician experienced in coordinating residency programs, University/Community hospital relationships and in-hospital postgraduate education programs. Competitive salary and excellent benefits. Consulting privileges considered. Submit resume, to: Chairman, DME Search Committee, Holy Cross Hospital, 2701 W. 68th Street, Chicago, Illinois 60629.

PATHOLOGIST WANTED: Board eligible, Illinois license for vacation coverage, \$600 per week. Contact: James Gross, M.D., pathologist, St. Mary's Hospital, Streator, Illinois 61364. Phone: (815) 673-2311 Ext. 219.

Positions & Practice Opportunities (Con't)

PSYCHIATRIST, Board Certified or eligible. **PHYSICIAN, INTERNAL MEDICINE**, Board Certified or eligible with subspecialty in cardiology. **GENERAL PRACTITIONER**. Salary open. Normal 40-hr. week. Liberal fringe benefits. Housing available. License any state required. Midwest city, 40,000 population, with excellent community schools, colleges and universities. Located near Interstate I-69, 65 miles north of Indianapolis, 50 miles south of Fort Wayne. Equal opportunity employer. Contact Chief of Staff, V.A. Hospital, Marion, Indiana 46952, or call Collect Area 317, 674-3321.

FULL TIME PHYSICIAN for Outpatient Department of Prepaid Health Plan. Five day 40-hr. week. No on call. Located in Central Illinois. New modern facility. Salary open. Tax shelter available. Contract administrator, Wabash Memorial Hospital Assn., 360 E. Grand, Decatur, Ill. 62525. Telephone: (217) 429-5246.

INTERNISTS: Prefer Bd. Cert. or Bd. eligible, opportunity for private, group practice. Offices, hospital based, newly constructed, plus renovated 200 bed, fully accredited acute care community hospital. Low overhead. Contact Administrator, Loretto Hospital, 645 S. Central Ave., Chicago, Ill. 60644. (312) 626-4300.

SHELL LAKE CLINIC, LTD., Shell Lake, Wisconsin, expanding to seven man group. Three family physicians and one surgeon desire additional **TWO FAMILY PHYSICIANS** and **ONE INTERNIST**. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call (715) 468-2711 or write to Clinic Manager, Darrell Bailey.

GENERALIST WANTED: for full-time student health position, 40-hr week, no on-call responsibilities, excellent community. Salary negotiable with liberal fringe benefits including 30-day vacation retirement plan. Illinois license. Write or call: Margaret M. Torrey, M.D. Illinois State University, Normal, Illinois 61761. Phone: (309) 438-8655.

PHYSICIAN FOR FAMILY PRACTICE—Our modern hospital located on the southeast side of Chicago is seeking a physician who is board eligible or a Diplomate of the American Board of Family Practice to establish a program in Family Practice and serve as its Director. A Fellow of the American Academy of Family Physicians is desired. Educational ties have been developed between our Hospital and the faculty of the University of Chicago Pritzker School of Medicine. You are invited to call or write: Dr. Bernard Lieb, M.D., Chief of Staff; Chairman, Intern & Resident Teaching Committee, South Chicago Community Hospital, 2320 East 93rd Street, Chicago, Illinois 60617; 312-978-2000.

PHYSICIANS to work full-time at one of various industrial sites in Midwest for a multinational company, which believes in promoting preventive medicine. **PLANT MEDICAL DIRECTORS** needed at some sites and an **INTERNIST** at one site. Excellent fringe benefit. Career opportunity. Write to Box Number 817, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Ill. 60601.

WANTED: GP/ANESTHESIOLOGIST. Carefully selected patients waiting—due to sudden death of GP/Anesthesiologist. Hospital one block from modern rented office. Call collect (419) 592-4706 or 592-4015.

WANTED: FAMILY PRACTITIONERS (2)—OB-GYN, PEDIATRICIAN to establish Group in small but attractive city of 6,000 S.E. Illinois; current physicians approaching retirement age, willing to give support. Patient service area approximately 12,000. Well-run hospital; good schools; prosperous, friendly community. Contact: Don Blomgren, phone: (618) 943-2381.

EMERGENCY MEDICAL SERVICES PHYSICIAN for new E.R. facilities of 200-bed JCAH Trauma Center hospital, with multispecialty clinics physically adjacent providing immediate consultation and support. Full department status. Contract arrangements negotiable for fee-for-service; or salary basis; and/or guarantee. Many fringe benefits, including flexible work-week and liberal vacation. Illinois license necessary. Area population (80,000). Modern community, excellent schools and Junior College. Contact: J. L. Berhow, Administrator, Community General Hospital, Sterling, Illinois 61081. (815) 625-0400.

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FOR RENT: OPHTHALMOLOGIST OFFICE, 55 East Washington Street, Chicago, Illinois (Pittsfield Building). Available several days a week; fully equipped. Beautifully furnished. Phone: DE 2-4884/IR 8-8770.

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PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone 815-725-1188.

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

FOR RENT: Suites available in a recently completed Medical Center just 1/2 mile from the new proposed Hospital in Barrington, Illinois. Each suite, 800 sq. ft., is elegantly finished and absolutely independent, incl. W/R, A/C, AM-FM, etc. Ample parking. Reply Box Number 815, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

FOUR CHICAGO MEDICAL CLINIC BUILDINGS—1 Uptown; 1 Near West; 2 South—each 7000+ sq. ft., fully equipped including 12+ examining rooms with plumbing; approved electrical throughout, central heat and air; each ready for immediate clinic operation. Call (312) ST 2-6006.

FOR SALE: Lucrative and well established General Practice in southwest Chicago. Second floor office situated over pharmacy. Will introduce. J. Dudek, 3753 S. Honore, Chicago, Illinois 60609.

MEDICAL BUILDING & APARTMENT FOR SALE—in Rockford area. Fully equipped 8 room medical suite, 6 room apartment above with many inclusions, 2 car garage—15 parking spaces. On 1/2 acre lot. Call Adams Real Estate, 312-498-1100, 1656 Shermer Avenue, Northbrook, Illinois, for full details.

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We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principle psychiatric teaching resource for the Medical College of Wisconsin has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employee fringe benefit program and salary. Send vita to.

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12	American National Bank	85	Milwaukee County Civil Service Commission
24	Associates, Inc.	14-15	Pharmaceutical Manufacturers Association
1-2	Blue Cross/Blue Shield	85	Walsh & Wright/ <i>Real Estate</i>
49	Chicago Lakeshore Hospital	84-85	Classified Advertising
75	Cook County Graduate School of Medicine	78-80	Physician Recruitment
50	Illinois Foundation for Medical Care		

Illinois Medical Journal

August, 1973 · Volume 144 · Number 2

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**legislative report
see page 107.**


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BLUE SHIELD REPORT



FOR *Illinois Physicians*

FALL SERIES OF WORKSHOPS FOR MEDICAL ASSISTANTS BEGINS IN AUGUST

The Blue Shield Plan of Illinois Medical Service will hold its Fall 1973 series of workshops for medical assistants in Cook, Kane, Lake, Will, Grundy and Du Page counties beginning August 29.

All the workshops will be daytime meetings of morning and afternoon sessions. The morning workshops will be held from 9:00 AM to 12:00 Noon, followed by a luncheon. Registration will begin at 8:30 AM. For those unable to attend in the morning, workshops will be repeated in the afternoon. Sessions will begin at 1:30 and adjourn at 4:30. All participants are invited to attend the luncheon.

The programs will be conducted by members of the staff of the Professional Relations Department and include changes in Medicare regulations, care for the disabled under 65, Blue Shield's under 65 supplement to Medicare and Blue Shield's benefits for employees of the State of Illinois. These topics will supplement the agenda of materials and information on other Blue Shield benefit programs and the Physician's Service Report forms.

Ample time will be provided for questions and answers. Workshops will be organized into groups not exceeding 20 participants with members of the Professional Relations Department assigned as instructors to each group. Special attention will be given to the newly employed assistant.

Letters are being sent to physicians' offices in the above counties to the attention of the Medical Assistant, announcing the new series and enclosing a reservation form listing the meeting locations.

Wednesday, Aug. 29	Holiday Inn South	Joliet
Wednesday, Sept. 5	Sheraton-Waukegan	Waukegan
Thursday, Sept. 6	Stouffer's	Oak Brook
Wednesday, Sept. 12	Holiday Inn	Oak Lawn
Wednesday, Sept. 19	Arlington Park Towers	Arlington Hts.
Wednesday, Sept. 26	Pheasant Run Inn	St. Charles
Wednesday, Oct. 3	Lincolnwood Hyatt House	Lincolnwood
Wednesday, Oct. 10	Ramada Inn	Dolton
Thursday, Oct. 11	Sheraton-North Shore Inn	Northbrook
Wednesday, Oct. 17	The Drake Hotel	Chicago
Thursday, Oct. 18	The Drake Hotel	Chicago
Wednesday, Oct. 24	Oak Park Arms	Oak Park
Wednesday, Oct. 31	Holiday Inn	Glen Ellyn
Wednesday, Nov. 7	Shoreland Hotel	Chicago

REASSIGNMENT OF BLUE SHIELD PHYSICIAN CODES

The Professional Relations Department of Blue Shield is currently verifying county code assignments of Illinois physicians, and has discovered many assigned codes to be inaccurate.

When the assigned code is in error, the physician is given a new code number in the proper county. A supply of Physician's Service Reports imprinted with the new physician code number is then forwarded.

Because of the problems created in the code

changes, Blue Shield designed a letter for enclosure with the new Blue Shield Physician's Service Reports advising the physician that his code number has been changed and that his supply of Physician's Service Reports are imprinted with the new number.

The physician is urged in the letter to use *only these new forms* for any future services to Blue Shield subscribers. The letter also states that if there are any questions concerning the change, the physician may call Blue Shield, Mrs. Kathy Wollscheid, (312) 661-4930.

ASK BLUE SHIELD

. . . ABOUT MEDICARE

COVERAGE OF ALLERGY TREATMENTS

Payment is made for allergy treatments by Part B Medicare under the following circumstances:

(1) When the allergist prepares and charges the patient for an allergenic extract and he administers the extract.

(2) If the extract is administered by another physician, the cost of the extract is covered only if the administering physician obtains the extract from the allergist and the cost is included in the administering physician's itemized statement to the patient.

(3) When the allergist charges the patient for the extract but another physician administers it, payment is made to the allergist for administering the extract but not for the extract itself.

Billing for Allergy Treatments

Allergists commonly bill separately for the initial diagnostic work and for the course of treatment that follows. When it is necessary for the physician to treat the patient for an extended period, the allergist may bill with one statement for all treatments or on a periodic basis, i.e., monthly or quarterly.

When billing periodically, charges for services are considered *incurred* under the Medicare program *at the time they are actually performed*. Charges for anticipated services are not considered incurred under the program. When billing on a one-statement, flat fee basis, caution must be observed that services were not performed prior to the beginning of a patient's coverage or after his coverage ended.

The SSA 1490 Request for Medicare Payment form should be submitted (1) after the last treatment charged on the billing statement has been given; or (2) when billing for all treatments during a calendar year, at the end of that calendar year.

Phaco-Emulsification Procedure Accepted for Cataract Extraction

Based on published studies and other available information, including recommendations of authoritative sources in the field of ophthalmology, the Bureau of Health Insurance, Social Security Administration has revised its policy on reimbursement for cataract extraction using the phaco-emulsification procedure. Necessary services furnished in connection with the procedure will be reimbursed for claims received on and after May, 1973 according to a recent revision to the Part B Medicare Manual.

Stickney Township Home Health Agency Withdraws from Medicare Program

The Stickney Township Public Health District, 5635 State Road, Burbank, Illinois will no longer participate in the Health Insurance for the Aged Program (Title XVIII of the Social Security Act) effective August 1, 1973. The agreement between the Stickney Township Public Health District and the Secretary of Health, Education and Welfare will be terminated in accordance with the provisions of the Social Security Act.

No payment will be made by the Medicare program for home health services furnished to patients whose plan of treatment is established on or after August 1, 1973. For patients whose plan of treatment is established before August 1, 1973, no payment will be made for services furnished after December 31, 1973. (Provider number of the Stickney Township Public Health District is 14-7022).

Revision to Data Published On Coverage of Vitamin B-12 Injections

Under the title "Coverage and Exclusions of Drugs and Biologicals"—May issue, *Illinois Medical Journal*—information published in Ask Blue Shield About Medicare on Vitamin B-12 injections included several neuropathies that are no longer considered covered under specific therapy by the Social Security Administration.

In the most recent revision to the Part B Intermediary Manual, Chapter II, "Coverage and Limitations on Drugs and Biologicals," information in the manual states that professional medical advice indicates vitamin B-12 injections are specific therapy for:

(1) Certain anemias—pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

(2) Certain gastrointestinal disorders—gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome;

(3) Certain neuropathies—posterolateral sclerosis, other neuropathies associated with pernicious anemia, the acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism.

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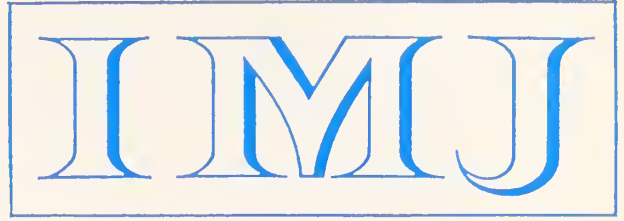
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Illinois Medical Journal

AUGUST, 1973

Vol. 144, No. 2

CONTENTS

Special Articles

- 107 Legislative Report
139 Doctor, What Do You Know About Venereal Disease?
-

Clinical Articles

- 117 Drug Treatment of Hyperactivity in Children
P. S. B. Sarma, M.D. and Marshall Falk, M.D.
- 120 Confusing Urinary Bladder Defects and Configurations
Charles Ney, M.D. and Harry L. Miller, M.D.
- 123 "The Way to a Man's Heart Attack . . ."
Richard J. Jones, M.D.
- 129 Multiloculated Cystadenoma of the Liver
Frederick Merchant, M.D.
- 134 Pediatric Perplexities: Repeated Bouts of Pneumonitis Cough With Feeding and Abdominal Distention
Hugh V. Firor, M.D., F.A.C.S., F.A.A.P.
-

Surgical Grand Rounds

- 131 Gas Infection of Thigh
John M. Beal, M.D., Editor
-

Trauma Center

- 137 A Statewide System For Post-Traumatic Renal Failure
George Dunea, M.D., M.R.C.P.

(Contents continued overleaf)

CONTENTS (continued)

Features

- 97 President's Page
- 104 Clinics for Crippled Children
- 128 View Box
- 136 EKG of the Month
- 142 Membership Forum
- 143 Doctor's News
- 146 New Pharmaceutical Specialties
- 148 Editorials
- 149 Illinois Society, American Association of Medical Assistants
- 150 Cooper Quiz
- 151 Doctor's Library
- 152 Pulse of the Doctor's Wife
- 162 Physician Recruitment
- 165 Obituaries

(Cover by Mike Ahearn)

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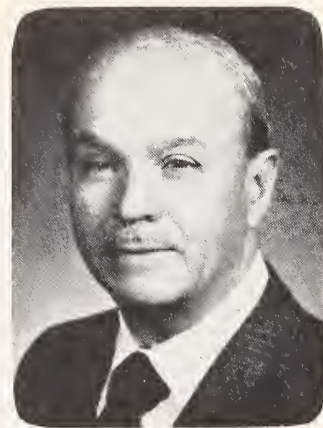
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This increased activity in the legislative arena demands increased activity on the part of *all* Illinois physicians!

Our legislative record thus far in the 78th General Assembly is an impressive one, as evidenced in the Legislative Report of this issue. And our victories were the result of involved physicians who provided expert testimony in committee hearings, reviewed technical proposals and took the time to contact their legislators and present medicine's position on key issues.

The overwhelming slate of bills introduced during each session makes it virtually impossible for legislators to study the implications of each proposal. It is our job to make them aware of the significance of pending medical legislation.

Legislators *are* willing to listen. But we must *speak out!* Unfortunately, too often we remain silent while other groups work untiringly to promote their special interests at the expense of our freedom, our doctor-patient relationship and the quality of medical care itself.

Too often we refuse to take the time to participate in legislative battles—yet willingly take the time to criticize and complain when we don't like the results on the legislative scoreboard.

We all have a vital stake in what's happening in Springfield. It's time for *all* of us—including members of our Women's Auxiliary—to speak out in support of legislation which is best for our patients and our profession.

The most effective way we can speak is through IMPAC. Because through IMPAC we can support candidates who will objectively consider our views and programs—the most effective way to insure that medical and health bills are drafted and controlled by as many friends of medicine as possible. The fate of wise men who do not take part in government is to be governed by unwise men.

Join IMPAC! Is \$25 too much to invest in your future? IMPAC members and other concerned physicians are talking to legislators and leading the fight to safeguard our rights and the rights of our patients.

They're doing their part!

Are you?

William E. Schwan M.D.

Unity + Strength = Effectiveness

WHEN
THE SQUEEZE
IS ON...





KINESED® RELEASES SPASM

Kinesed® can effectively counteract the spasm, hypermotility or hypersecretion that often occurs in:

gastroenteritis/colitis

peptic ulcer

gastritis/duodenitis

spastic/irritable colon.

Provides belladonna alkaloids for potent antispasmodic and antisecretory action.

Also provides simethicone for accompanying distention and pain due to gas. And phenobarbital—for associated anxiety and tension.

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

Children 2 to 12 years: One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

KINESED®

antispasmodic/sedative/antiflatulent

Each *chewable tablet* contains: 16 mg. phenobarbital (warning: may be habit-forming), 0.1 mg. hyoscyamine sulfate, 0.02 mg. atropine sulfate, 0.007 mg. scopolamine hydrobromide, 40 mg. simethicone.



STUART PHARMACEUTICALS | Div of ICI America Inc.
WILMINGTON, DEL. 19899

What the Sleep Research Laboratory recorded about DALMANE[®] sleep...¹

(flurazepam HCl)

- ☐ reduced sleep latency
- ☐ decreased time awake after sleep onset
- ☐ increased total sleep time

The polygraphic techniques of the sleep research laboratory have objectively documented the value of Dalmane (flurazepam HCl) for patients with difficulty falling asleep or staying asleep.

Hundreds of hours of monitored sleep¹⁻⁹ have shown that one 30-mg capsule of Dalmane at bedtime generally induced sleep within 17 minutes, significantly reduced time awake after sleep onset and provided 7 to 8 hours of sleep. Dalmane effectiveness was maintained even over 14 consecutive nights of administration, demonstrating the consistent effectiveness of Dalmane.



REFERENCES

1. Kales, J., et al.: *Clin. Pharmacol. Ther.*, 12:691, 1971. 2. Frost, J.D., Jr.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. 3. Karacan, I., et al.: "The Sleep Laboratory in the Investigation of Sleep and Sleep Disturbances," Scientific Exhibit presented at Amer. Psychiat. Assoc., Washington, D.C., May 3-7, 1971. 4. Kales, A., et al.: *Arch. Gen. Psychiat.*, 23:226, 1970. 5. Dement, W.C.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. 6. Kales, A., and Kales, J.: *Pharmacol. Physicians*, 4:1, 1970. 7. Kales, A.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology*, Philadelphia, Lippincott, 1969, p. 331. 8. Vogel, G.W.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. 9. Kales, A., and Kales, J.: *J.A.M.A.*, 213:2229, 1970.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though

physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were

headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



What the patients reported when they awoke¹

- ☐ more rapid sleep induction
- ☐ increased duration of sleep

The utility of any sleep medication depends, ultimately, on patient acceptance. For this reason, sleep laboratories evaluating Dalmane (flurazepam HCl) have obtained the patients' own estimates of their sleep immediately on awakening in the morning. These subjective evaluations have been in strong agreement with the polygraphic records, confirming polygraphic evidence of Dalmane effectiveness compared to placebo.

Morning "hang-over" with Dalmane has been relatively infrequent. In most instances, adverse reactions, when reported, were mild and infrequent. Dizziness, drowsiness, lightheadedness and the like have been side effects noted most often, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

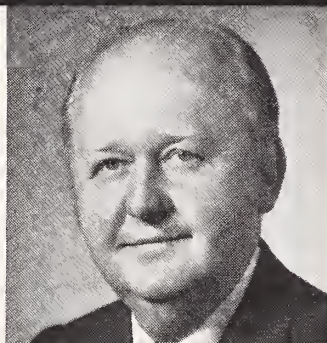
Dispenser of
Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of
Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients . . .

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care. For 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Clinics for Crippled Children Stated for September

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 4	Carmi—Carmi Township Hospital
September 5	Hinsdale—Hinsdale Sanitarium
September 6	Sterling—Sterling Community Hospital
September 6	Lake County Cardiac—Victory Memorial Hospital
September 6	Effingham—St. Anthony Memorial Hospital
September 6	Macomb—McDonough District Hospital
September 10	Peoria Cardiac—St. Francis Children's Hospital
September 11	Peoria—St. Francis Children's Hospital
September 11	E. St. Louis—Christian Welfare Hospital
September 12	Joliet—St. Joseph's Hospital
September 12	Champaign-Urbana — McKinley Hospital
September 13	Springfield—St. John's Hospital
September 13	Anna—Union County Hospital
September 14	Chicago Heights Cardiac—St. James Hospital
September 18	Rock Island—Moline Public Hospital
September 18	Alton—Alton Memorial Hospital
September 19	Evergreen Park—Little Company of Mary Hospital
September 19	Jacksonville—Norris Hospital
September 20	Elmhurst Cardiac—Memorial Hospital of DuPage County
September 20	Decatur—Decatur Memorial Hospital
September 20	Rockford—Rockford Memorial Hospital
September 24	Peoria Cardiac—St. Francis Children's Hospital
September 25	Peoria—St. Francis Hospital
September 25	Belleville—St. Elizabeth's Hospital
September 26	Elgin—Sherman Hospital
September 26	Centralia—St. Mary's Hospital
September 28	Chicago Heights Cardiac—St. James Hospital

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T₄) and Sodium Liothyronine (T₃). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T₄ and T₃ in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T₃ ¹³¹I resin sponge uptake, T₃ ¹³¹I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T₄ and T₃ is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?

Unlike U.S.P.
desiccated thyroid,
Proloid® (thyro-
globulin) offers
the assurance of
constant potency.

To begin with,
Proloid is uniquely
purified. The

thyroglobulin extracted from hog thyroid is devoid of any glandular debris.

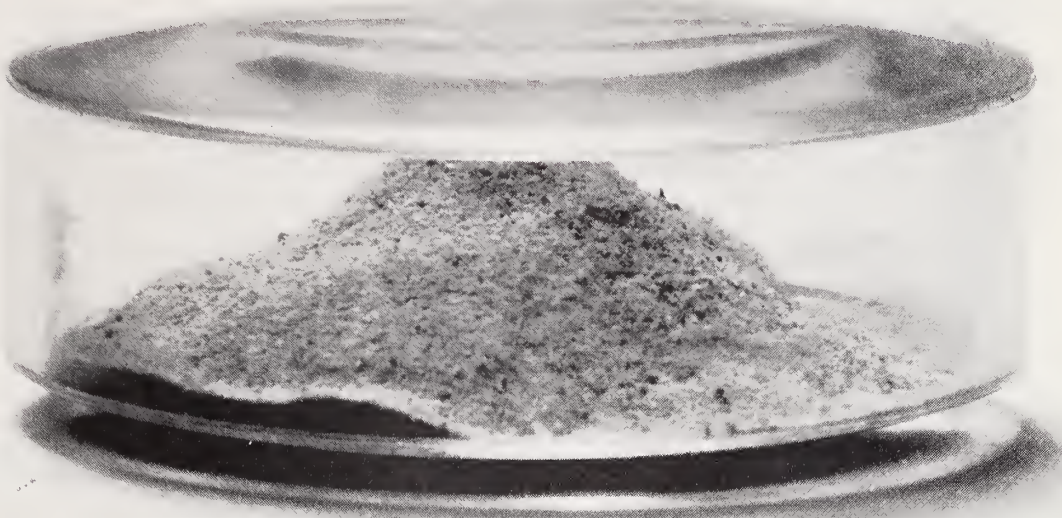
Then, Proloid is chemically and biologically assayed to assure consistent metabolic activity from batch to batch. The T_4 and T_3 content of every dose is blended for optimal thyroid replacement.

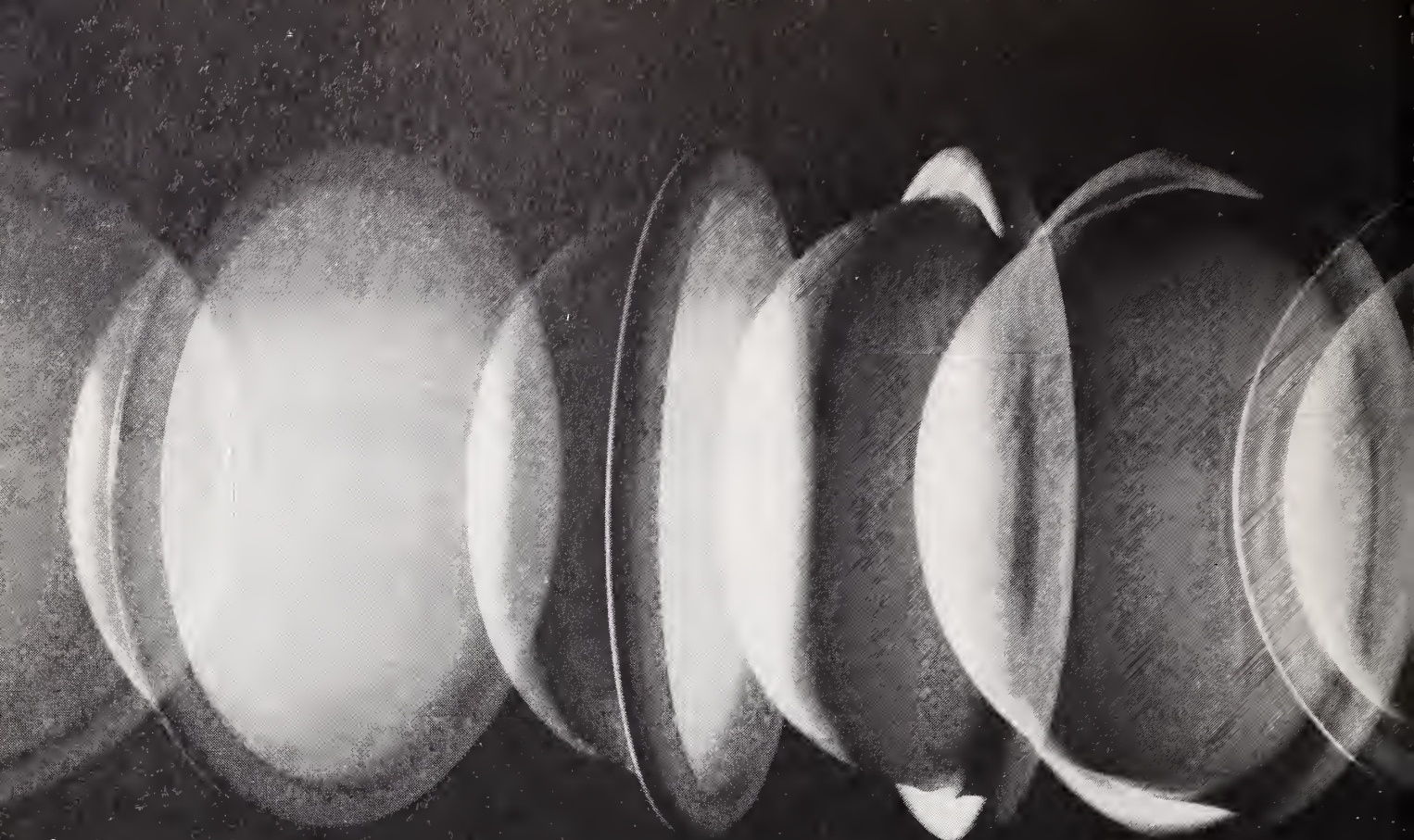
Important, too, is the fact that Proloid is invariably "fresh" when your patients take it. Under proper storage conditions, its potency will not diminish for at least four years.

All of which adds up to this: the potency of Proloid is constant...for more consistent results.

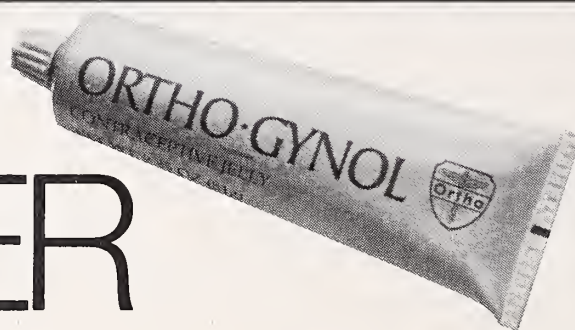
PROLOID® **(thyroglobulin)**

natural thyroid therapy
that leaves
nothing to chance





A VERY SOUND BARRIER



For patients who can't or won't use the "pill" or an IUD

While no contraceptive is one hundred percent effective, the Ortho All-Flex Diaphragm and Ortho-Gynol Contraceptive Jelly, together, act as a very effective barrier to conception and is a method that is rarely contraindicated.

Ortho All-Flex is designed to provide comfort and reliability and to meet the highest esthetic standards of the most discriminating women.

Ortho All-Flex Diaphragms are made of high quality, long-lasting latex. They won't discolor when used with Ortho-Gynol Contraceptive Jelly or Ortho-Creme* since these contain no phenylmercuric acetates. No introducer is needed; the unique spring-within-a-spring construction forms a perfect arc wherever compressed.

Consider the advantages of prescribing the Ortho All-Flex Diaphragm and Ortho-Gynol when you and your patient decide on the diaphragm and jelly method of conception control.



If you would like a professional fitting-ring set and fitting-procedure brochure, please contact your Ortho representative.

Ortho Pharmaceutical Corporation, Raritan, New Jersey 08869

The Ortho All-Flex* Diaphragm with Ortho-Gynol* Contraceptive Jelly

*Trademark

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Legislative Report

The great and growing interest of Illinois citizens—and their legislators—in medical and health care was reflected by the huge number of health-oriented bills introduced in the recent session of the General Assembly. Of the 3,210 measures considered by the legislature, about 500 were related to health care, and about 300 of those were of significant interest to medical practitioners.

Major issues ranged from abortion—three bills setting abortion guidelines and supported by the Illinois State Medical Society were passed—to a proposed omnibus consumer measure which would have created a “super board” to set proficiency-equivalency standards for health care professionals, and also establish a grievance board to investigate consumer complaints against health care providers.

ISMS considered the latter bill an ill-conceived and poorly written measure which would hamper and harass physicians. The state medical society, with the help of members, their wives, medical assistants and other health care professionals, worked hard to defeat this bill, but it is likely that some parts of it will be revived when the General Assembly meets again in October.

A few of the bills which were passed and will have significant effect upon medical practice are included in the analysis on these pages.

ABORTION BILL 'PACKAGE' PASSED

A "package" of three bills regulating abortions was passed by the General Assembly in Illinois' first legislative action since the Supreme Court ruled in January that the state cannot interfere in a doctor-patient decision to perform an abortion in the first trimester of pregnancy.

The bills were Senate Bill 1049 (Illinois Abortion Law), which set guidelines for abortions; Senate Bill 1050 (Amendment to Medical Practice Act), which restricts performance of abortions to licensed facilities, and Senate Bill 1051 (Ambulatory Surgical Treatment Center Act), which defines ambulatory surgical centers and sets certain regulations for them.

The key measure, S.B. 1049, would permit only physicians to perform abortions at any time during pregnancy. During the second trimester, a physician may perform an abortion only in a hospital and on an in-patient basis and where life support equipment is available. In the third trimester, two other physicians must agree that abortion is necessary to preserve the life, physical health or mental health of the mother. The measure provides for informed consent, and also requires that counseling and laboratory procedures must precede the abortion, and care and counseling be provided following surgical procedure. A "conscience clause" protects physicians refusing to perform abortion from civil, criminal, administrative or disciplinary action.

S.B. 1049 also provides that if an abortion is performed during the first 20 weeks of pregnancy the physician must file a report with the Illinois Department of Public Health. Reports will remain confidential but could be used for statistical purposes to determine where there is need for greater emphasis on contraception and family planning, or for improved medical facilities and patient care. The Vital Records Act already requires physicians to report to IDPH all abortions performed after 20 weeks of gestation. Another provision of this bill requires that a pathologist examine all tissue removed during the abortion procedure, and prohibits experimentation upon aborted tissue.

S.B. 1050 restricts performance of abortions to licensed facilities, including ambulatory surgical centers. It also amends the Medical Practice Act to make performance of elective abortion in an unlicensed facility grounds for placing the physician on probation, or suspending or revoking his license to practice medicine.

The third measure, S.B. 1051 (Ambulatory Surgical Treatment Center Act), while not directly related to abortion, would assure that such procedures are carried out only in licensed and

Although signed by Governor Walker, the effective date of abortion measures passed by the General Assembly may be postponed until July 1, 1974. The Illinois Constitution states that bills passed after June 30 do not become law until July 1 of the following year if an earlier date is not mandated by a three-fifths vote of the Assembly.

The House vote on July 1—which sent the bills to Governor Walker—met the three-fifths provision, but the Senate vote a month earlier did not.

Upon signing the bills, Governor Walker declared them effective immediately. At time of publication it is not certain the governor's declaration actually has the effect he intended.

regulated facilities. The bill defines an ambulatory surgical treatment center as a facility devoted primarily to medical and surgical procedures—including abortions—which normally would not require overnight hospital stay. Centers would in fact be prohibited from providing beds or other accommodations, but would be required to transfer to a hospital any patient in need of additional care.

To qualify for licensure, ambulatory centers must be under the medical supervision of one or more physicians. Only licensed physicians and dentists with hospital privileges to perform surgery could practice in ambulatory centers, and medical records must be maintained for each patient.

Regulation and licensing of such centers would be the responsibility of the Illinois Department of Public Health. In addition, the governor would appoint a licensing board composed of four physicians, an oral surgeon, a registered nurse working in an ambulatory center, a supervisor or administrator of a health facility, and two consumer representatives.

The ambulatory surgical center bill was strongly supported by the Illinois State Medical Society in the belief that such facilities may help to slow the rapid rise of health care costs by providing an alternative to expensive hospitalization. Also, ISMS believes that ambulatory centers will free hospital beds needed for the seriously ill, and reduce the need for hospital expansion. In at least one city where such centers have been operating, hospitals have reduced some of their charges.

CONTROLLED SUBSTANCES ACT REVISED

Physicians have been freed of the additional paperwork and threat of investigation involved in prescribing many items under Schedule II of the Illinois Controlled Substances Act.

By passing Senate Bill 982, the General Assembly created a "designated product" category in Schedule II which limits prescription items requiring the triplicate prescription form. The director of the Illinois Law Enforcement Commission will designate which highly abused products will be included in the new category.

In addition to substantially reducing paperwork for physicians and pharmacists, the bill should also result in more effective control by law enforcement agencies of illicit traffic in highly abused substances.

AID FOR AMBULANCE SERVICES

Illinois ambulance services plagued by financial troubles have been given aid by new legislation permitting county tax support and requiring direct payment from insurance companies. Two bills aimed at preserving existing levels of service and providing a financial base for improvement of service were the result of a two-year study of ambulance operations outside Cook County. The survey was made by a subcommittee of the Motor Vehicle Laws Commission.

House Bill 1210 authorizes non-home-rule county governments to levy a tax—following approval by a referendum—or use general funds to contract with or subsidize private ambulance operations. The bill also authorizes counties to provide services themselves or in conjunction with other units of government.

The second measure—House Bill 1126—requires all motor vehicle liability insurance policies issued or renewed after November 1, 1973, to include a provision for direct payment for emergency services by ambulance operators.

"GOOD SAMARITAN" CONCEPT EXPANDED

The General Assembly passed a sound public health measure and possibly improved the malpractice climate in Illinois by extending the Good Samaritan concept to emergency care rendered *anywhere, anytime*.

Senate Bill 450 amends the Medical Practice Act to exempt from civil liability physicians, who in good faith, without prior notice of the illness or injury and without fee, provide *emergency* care. Previously the Good Samaritan concept applied only at the scene of an accident or in case of nuclear attack.

This bill, which was strongly endorsed by ISMS, does not exempt physicians from willful and wanton misconduct or criminal liability.

ANATOMICAL GIFT ACT CHANGED

Availability of organs and tissue for transplantation should increase significantly because of amendments to the Anatomical Gift Act passed by the General Assembly.

Under Senate Bill 896, permission for donation of an anatomical gift now can be given by any one of the following survivors, listed in order of priority: spouse, adult son or daughter, adult brother or sister, guardian, or a person authorized or under obligation to dispose of the body. Previously, permission was required from all survivors in any one familial category.

The bill was supported by ISMS and vigorously endorsed by the Illinois Society for the Prevention of Blindness, which maintained that the original requirement seriously hampered its "eye bank" program.

CAN YOU SPARE A WEEK IN SPRINGFIELD?

ISMS is considering initiating a "Doctor of the Week" program to give on-the-scene physician input during the balance of the 78th General Assembly. This program would place a different physician in Springfield each week of the legislative session to provide medical expertise for ISMS staff. He also would testify before House and Senate committees, meet key legislators and participate in other activities. ISMS would pay expenses of participating physicians and give at least two months notice of physician scheduling. If you are interested in participating please complete and mail this form to ISMS headquarters.

NAME _____ TELEPHONE _____

ADDRESS _____ CITY _____

Other Action by The General Assembly

Professional Disciplinary System

H.B. 1167 and 1168, which would have reorganized the state's medical disciplinary system, were *defeated* in the House. ISMS is drafting proposed legislation seeking to reorganize present medical disciplinary procedures of the Department of Registration and Education.

Rubella Testing Awaits Repeal

H.B. 35 would repeal an act passed in 1971 requiring a woman planning to marry to be tested for immunity to rubella (German measles). This repealer—supported vigorously by ISMS—passed the Assembly, now awaits Gov. Walker's signature.

Also Exempted

S.B. 110, which provides liability exemption for patients, doctors and hospitals involved in blood transfusions, was *passed* and signed by Gov. Walker. ISMS vigorously supported this measure.

Medical Examiners Out

H.B. 687, which would have created a statewide medical examiner system, (eliminating coroners' offices existing in most counties) was *defeated* on the House floor. ISMS was instrumental in developing this bill, and will introduce similar legislation in 1974.

In Study Committees

Three bills have been assigned to interim study committees for possible redrafting and consideration in the fall session. H.B. 1403 (Certificate of Need) provides that all licensed health facilities must be co-ordinated with a statewide plan developed by the Comprehensive Health Planning Agency; also, construction, expansion and increases in services must be based on demonstrated need. S.B. 955 would supplant state departments of Public Health, Mental Health, Public Aid and Children and Family services with a "super agency." S.B. 1128 would regulate HMOs. ISMS is prepared to submit amendments if it appears 1128 will be reported out of committee. ◀

Must vasodilators
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The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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In Gonorrhea

Injection WYCILLIN®

(sterile procaine penicillin G suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae*: acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity.

Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisiphilics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by deep intramuscular injection, in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae*. Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages.

And destroy another link in the chain of infection.

In Syphilis

Injection

BICILLIN® Long-Acting
(sterile benzathine penicillin G
suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If

allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisypilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by deep intramuscular injection in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyper-excited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

If there's good reason to prescribe for psychic tension...



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reassurance and counseling
on repeated visits
are not enough

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2-mg, 5-mg,
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Placidyl® (ETHCHLORVYNOL)

Brief Summary

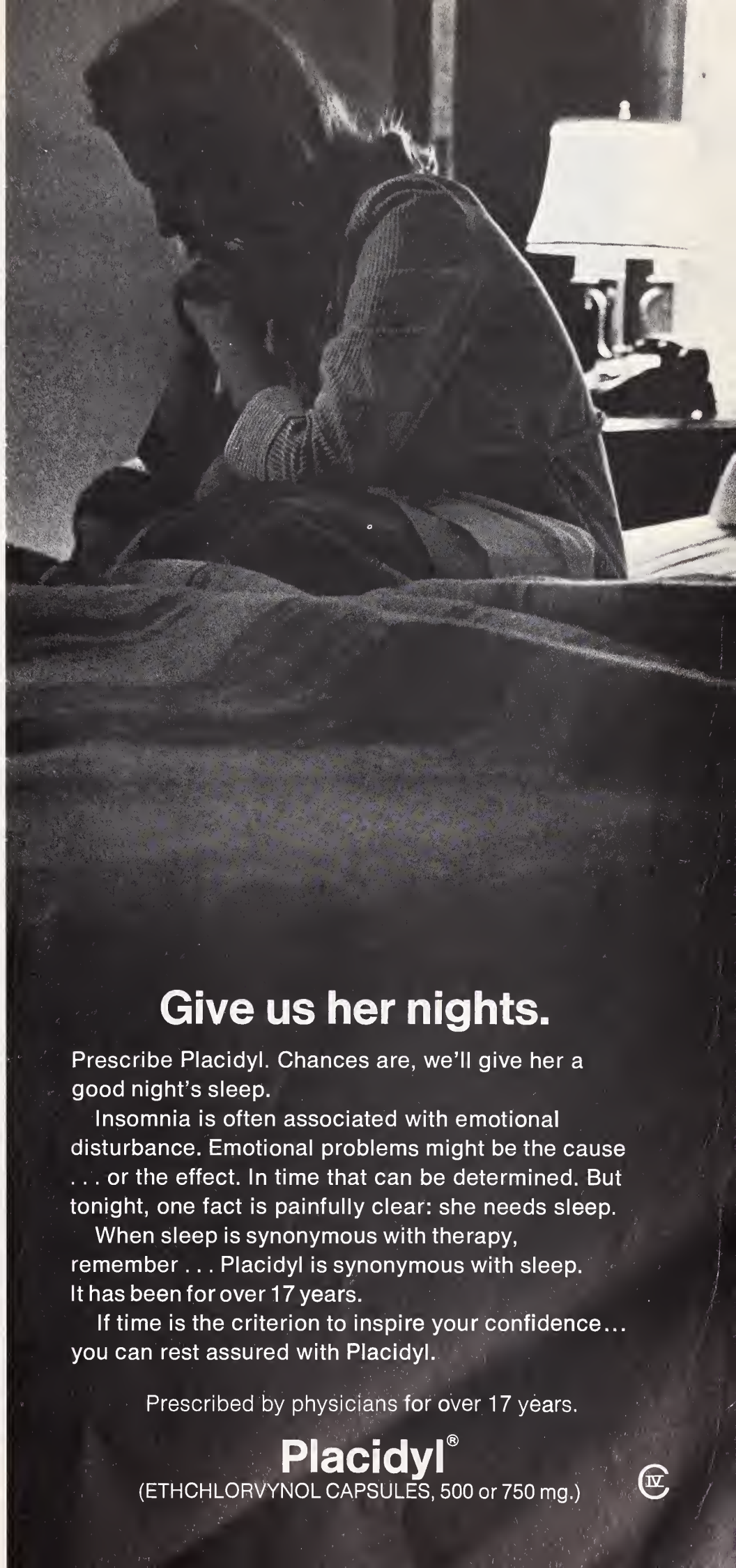
Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R



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Insomnia is often associated with emotional disturbance. Emotional problems might be the cause . . . or the effect. In time that can be determined. But tonight, one fact is painfully clear: she needs sleep.

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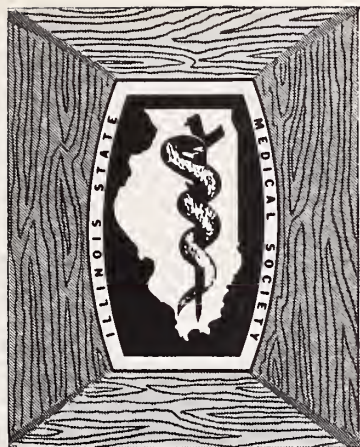
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IMJ

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Drug Treatment of Hyperactivity in Children

BY P. S. B. SARMA, M.D., AND MARSHALL A. FALK, M.D./CHICAGO

The syndrome of the hyperactive child has been haunting the physicians, teachers and families of such afflicted children for years. The treatment, as well as the syndrome, has been elusive and difficult to define. A review of some of the recent literature related to the treatment of the hyperkinetic child is presented with some definite conclusions and recommendations which the practicing physician might find useful.

Perhaps one of the most confusing, yet verbosely written about, syndromes in children is that related to the so-called hyperactive, hyperkinetic, or minimally brain-damaged child. It is no surprise then that such turmoil exists considering there is no definitive agreement among physicians on the diagnostic criteria for such a syndrome. Hyperactivity in children has been of concern to teachers, family members, counselors, psychologists, clergy, as well as members of the medical profession. In spite of the "popularity" of the syndrome (its social, medical and psychiatric implications), its vagueness not only continues to exist but is compounded by reports in the literature of treatment successes and failures.

It would seem obvious that in order to measure treatment effectiveness accurately, the syndrome being treated must be sharply defined. Since this sharp delineation has not been ac-

complished, not only in the syndrome of hyperactivity of children, but in most syndromes that are characterized by behavior disorders, treatment modalities of these syndromes also will be vague and conflicting. All this should not relieve physicians of their responsibility to use whatever medications are available and safe to relieve the social and medical suffering caused by this syndrome of hyperactivity in children. A brief review of the recent history of the medical treatment of this condition might help physicians choose their drug of choice more intelligently.

History of Treatment

Bradley,¹ in 1937, first reported on the effectiveness of amphetamines in the treatment of behavior disorders for children. In a later publication,^{2,3} he reported a favorable response rate of 50 to 60% with dextroamphetamine. As early as 1957, Laufer⁴ and his associates demonstrated



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and completed a fellowship of the Institute for Juvenile Research in Chicago.



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differences between hyperkinetic and normal children and the effectiveness of dextroamphetamine in an experimental setting. They studied the threshold for photometrazol activation of EEGs in children with hyperkinetic impulse disorders and normal children. They found that the hyperkinetic children had a significantly lower threshold. They also demonstrated that administration of "clinically effective doses" of amphetamine produced a significant increase in their threshold approaching the normal group. They suggested that probably amphetamine alters the functions of the diencephalon and reticular activating system by "raising the level of synaptic resistance."

Conners⁵⁻⁷ and his associates studied extensively the clinical effectiveness of both dextroamphetamine and methylphenidate in hyperactive children. They reported that amphetamine appeared to have produced a more vigorous and determined performance in these children. They did not rule out the possibility that the test situation itself might have had some part in this change. No change was noted in their intellectual ability.

Weiss and Laties⁸ found that in adults, amphetamines can decrease reaction time, improve steadiness and coordination, enhance monitoring behavior and hasten the acquisition of simple conditioning responses. Zrull et al⁹ found dextroamphetamine to be superior to diazepam and placebo in controlling hyperkinetic behavior in children. Campbell et al¹⁰ studied the cognitive styles in hyperactive children and the effect of methylphenidate. They found that methylphenidate produced less impulsive responses and improved ability to inhibit incorrect responses. Weiss et al¹¹ compared the stimulants with chlorpromazine and reported that methylphenidate was far superior. They stated that chlorpromazine only reduced hyperactivity, it did not have any demonstrable effect on distractibility, aggressivity or excitability. In contrast, the stimulants produced more goal-oriented behavior and less distractibility. Stimulants, in general, have proved to be superior to tranquilizing agents, perhaps through a stimulation of a dampening area of the brain.

In the last five years, a lot of attention has been given to the process of defining the type of hyperactivity that is likely to respond to the stimulant drugs. Attempts have been made to differentiate organic hyperactivity from functional hyperactivity. In this process, more and more focus has been on the neurological correlates. This has resulted in giving various labels

to the "organic condition," e.g., "hyperkinetic child," "minimal brain-damage syndrome," "minimal cerebral dysfunction," etc. There was a recent compilation by Werry¹² and his associates, of over 100 findings from neurological examinations accompanied by complicated statistical analysis. There have been many other attempts made to sift out responders to stimulants from non-responders. Barcai¹³ published a report on his "finger twitch test" which is a very simple clinical measure, and using this test he was able to arrive at an over 80% response rate to amphetamines. This is the highest reported positive response rate in the literature. This coincides with the report in 1970 by Millichap¹⁴ after a review of the literature.

Satterfield¹⁵ and his associates differentiated their subjects into two groups by using EEG and skin conductance level measurements. One group, they show, had a lower CNS arousal initially which coincided with the group which responded better to methylphenidate.

While all this was going on, Rapoport¹⁶ in 1965 reported his successful experiences in treating childhood behavior and learning problems with imipramine. There was scant attention paid to this, even though by this time, imipramine had attracted attention as an initial treatment approach in enuresis with children,¹⁷⁻¹⁹ and in some of these reports, behavioral improvement was an incidental finding.^{19,20}

Huessy and Wright²¹ in 1970 reported a marked improvement in 67% of the 52 children they treated with imipramine. They considered imipramine to be superior to dextroamphetamine and methylphenidate because the latter drugs often required more than one dose per day, whereas imipramine did not. They also found very minimal side effects with imipramine in those who responded to it. Over 65% of those who did not respond to imipramine, responded to methylphenidate. They considered imipramine to be the drug of choice in the treatment of the hyperkinetic syndrome.

During this period, most child psychiatrists were still under the powerful influence of the psychoanalytic doctrine and tended to shy away from using drugs. A remarkable amount of discussion during this period was related to stimulants because of the controversies in medical and political circles about prescribing for innocent children those devilish drugs with a renowned potential for addiction.

Recently, Winsberg²² and his associates reported a systematic comparison of imipramine and dextroamphetamine in treating neuropsychiat-

rically impaired children. Imipramine, like dextroamphetamine, had its effect on aggression and hyperactivity. It had an effect on inattention also. Furthermore imipramine was effective in many hospitalized children who had failed to respond to dextroamphetamine. Although imipramine was known to cause unfavorable reactions in liver and blood, it actually caused less disruptive side effects than dextroamphetamine. The latter in their estimation and earlier in Bradley's estimation caused unfavorable side effects ranging in severity from irritability to florid psychosis in about 10 to 15% of subjects. They advocate some treatment strategies that may be effective in the management of drug tolerance. For example, cyclical schedule of five days on and two days off; or an alternating schedule of one week on one, and another week on the other drug.

In addition to the above-mentioned drugs, amitriptyline^{23,24} diphenhydramine hydrochloride, acetazolamide²⁵ and two new drugs, namely, deanol acetamidobenzoate²⁶ and pemoline have been reported as showing some promise in the treatment of hyperactive children. Of course, the tranquilizers chlorpromazine^{27,28} chlorthalidazine²⁹ reserpine and molindone³⁰ have been found to be effective by some workers though not to as high a degree as the stimulants or imipramine.

Conclusion

All this leaves a wild field, not unlike the situation with the major and minor tranquilizers in the 60's. However, after all is said and done, there are three major drugs: (1) dextroamphetamine, (2) methylphenidate and (3) imipramine that have established themselves as drugs of choice. In view of the habituation propensities of the stimulants and the possible abuse by others in the family and possibly by the child itself after the hyperactivity disappears, as well as the reports of more frequent side effects with them, it may be advisable to consider imipramine as the first choice. However, this has to be considered with the possible problems of long-term treatment that may occur with any agent.

The contributions that future research makes toward further delineation of the biochemical and clinical correlates of hyperactivity will have to be examined with the aim of developing more specific indications for these three drugs and others that may come into the picture. ◀

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(Continued on page 156)

Confusing Urinary Bladder Defects and Configurations

By CHARLES NEY, M.D. AND HARRY L. MILLER, M.D./NEW YORK

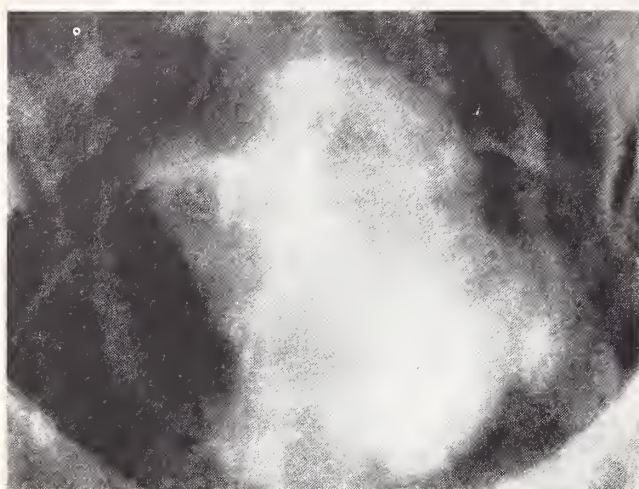


Fig. 1. Irregular defect on lateral aspect of right side of the bladder with slight hydroureter is very difficult to distinguish from a primary bladder neoplasm.



Fig. 2. The defect in Fig. 1 is shown to be due to a ureterocele as depicted on this late film.

There are numerous articles and texts depicting the various congenital and acquired abnormalities of the bladder. However, there are only scattered references to displacement and filling defects which are not essentially due to primary bladder disease. Presented are seven examples of such abnormal configurations which easily could be confused with serious pathology.

Case I: Fig. 1 shows, on the right side of the bladder, a large filling defect. This could be misinterpreted unless the late film (Fig. 2), clearly depicting the ureterocele, had been obtained.

Case II: Fig. 3 demonstrates a low-lying bladder with an irregular filling of the mid-superior portion. This easily could be interpreted as being due to an extrinsic mass causing pressure on the bladder. The lateral view (Fig. 4) of the cystogram discloses a ventral herniation of the bladder. (Gironcoli hernia).¹

Case III: Fig. 5—Cystogram from an I.V.U. reveals a large pressure defect on the left side of the bladder which appears to be slightly displaced to the right. A more extended view of the pelvis and upper part of the left thigh depicts a huge scrotal hernia which is the cause of the displacement and pressure on the bladder (Fig. 6).

Case IV: Fig. 7 reveals bilateral caudal elongation of the lateral sides of the base of the bladder

with a well sustained straight bladder neck. This patient had a previous cystocele repair with a well-corrected mid-portion of the cystocele, but with incomplete correction of the lateral margins inferiorly. This could be confused with a midline vaginal mass impressing the floor of the bladder in its mid-portion. A second consideration would be herniation of the bladder bilaterally.¹

Case V: Fig. 8 illustrates fecal impaction^{2,4,5} producing a filling defect on the left side of the bladder with fecal material shown in the rectum producing this abnormality. This type of defect could well be produced by any mass in the pelvis.



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Fig. 3. Prone film showing irregular defect and protrusion of opaque material on the superior aspect of the bladder. This defect also was demonstrated, but not as prominently, on the supine film.



Fig. 4. Lateral view demonstrates Fig. 3 defect to be due to anterior abdominal wall bladder herniation.



Fig. 5. Displacement of bladder to right due to extrinsic pressure on the left side of the bladder presenting as a smooth regular defect.



Fig. 6. The above pressure defect is shown to be due to bowel incorporated in a huge scrotal hernia which is only shown on an extended view of pelvis and hips.



Fig. 7. Bilateral elongation at base of bladder wall with straightening of mid-portion of base due to residual of cystocele. This could be confused with herniation.

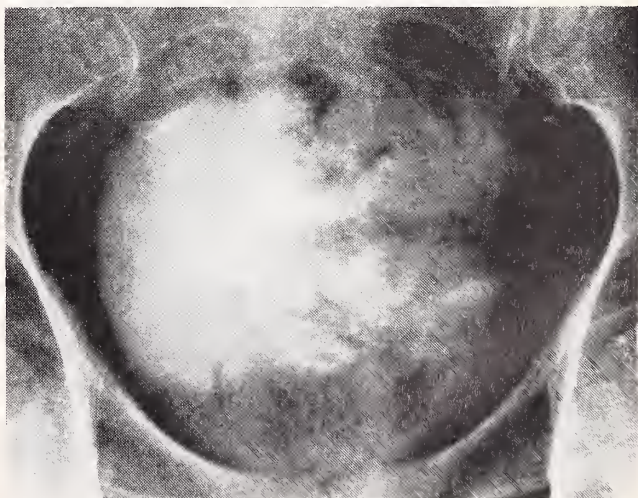


Fig. 8. Fecal retention and impaction producing irregular contrast outline on the left side of the bladder. The fecal material is clearly seen in the rectum.

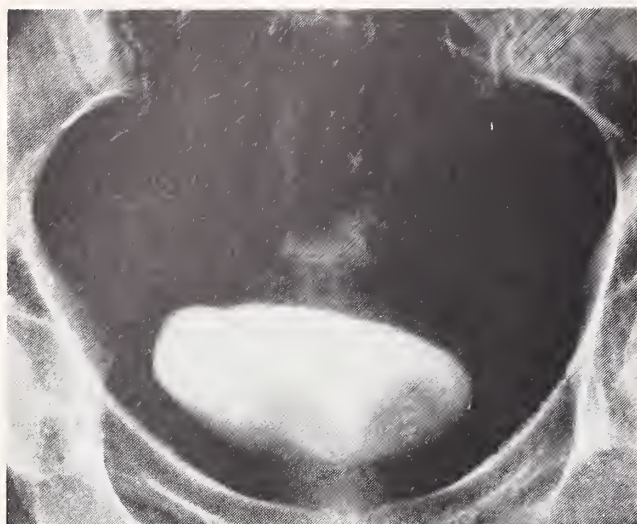


Fig. 9. Impression upon base of bladder due to Levator Ani muscles. Note the equal and bilateral impression on the inferior aspect of the bladder.



Fig. 10. Circular, well-defined lucency in bladder thought to be a lucent stone.



Fig. 11. The above defect is due to a subcervical prostatic lobe note the "Y" effect at the bladder neck.

Case VI: Fig. 9—Levator Ani muscles³ indenting the bladder at its base on either side of the trigonal area.

Case VII: Cystogram of an I.V.U. showing a circular, well-defined, lucent defect in the bladder which was thought to be a non-opaque calculus. The floor of the bladder is somewhat elevated by an enlarged prostate. Injecting cystourethrogram in the right oblique view shows a "Y" effect at the bladder neck with a large circular lucent area within the bladder, which is diagnostic of a subcervical prostatic lobe.

Discussion

Confusing configurations of the bladder are often seen on I.V.U. Correct interpretations depend on an intimate knowledge of the various possibilities which could cause such configurations. Late exposures of I.V.U. will sometimes clarify the situation as in Case I (ureterocele). Usually, however, retrograde cystograms are required, remembering that overdistention and excessive concentration of contrast material obscures pressure and filling defects. Case II (Girncoli hernia) requires a special retrograde cystogram view. Extended views as in Case III (scrotal hernia) may be necessary. In Case IV (cystocele repair) and Case V (fecal impaction) retrograde cystograms are illustrated because of better visualization. In none of these cases is cystoscopy especially helpful. In Case VII an injecting cystourethrogram is diagnostic because of the "Y" effect of the bladder neck.

Summary

Various confusing configurations of the bladder are demonstrated and the methods of determining the correct diagnosis are discussed. ◀

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“The Way to a Man’s Heart Attack . . .”

BY RICHARD J. JONES, M.D./CHICAGO

“The way to a man’s heart *attack* is through his stomach.” Just as a girl must be careful what she feeds a man, if she’s to lure him to the altar; so must she take care what she feeds him after marriage, if this paraphrase of an old aphorism is really true. This article reviews the nature and the quality of the evidence for the possibility that an important factor in coronary disease is the food we eat.

Myocardial infarction is usually the consequence of coronary artery occlusion so that these terms are sometimes loosely used as synonymous. Actually, in about a third of autopsied cases of myocardial infarction, there is no complete obstruction, but only a severe narrowing of the artery.¹ It is rare to have myocardial infarction without any arterial disease; but this can occur and provides one of those enigmas that haunt us when we attempt to explain the mechanisms of this disease.² Usually, a heart attack occurs when the circulation is obstructed, or at least severely compromised, and a portion of the myocardium becomes injured by lack of oxygen and substrates. A smaller central portion actually dies if the circulation is not restored in about 20 minutes, but a zone of injury may remain for several days, perhaps even weeks. It is this zone of living but injured tissue that is capable of setting up abnormal electrical currents which can throw the heart into a sometimes fatal ventricular arrhythmia. It is felt that such arrhythmias must explain the great number of patients who die suddenly. Eventually, if the patient recovers, scar tissue replaces the weakened dead muscle and the zone of injury regains a more nearly adequate blood supply.

Of patients reaching the hospital, only 15-20% succumb; the remainder recover, usually returning to full activity after a few months. However, according to the careful study in the community of Framingham, Massachusetts,³ about 40% of

the patients never get to the hospital. Assuming all sudden deaths were due to coronary disease, 22% died without ever getting medical attention because symptoms were of such short duration, while in 16% symptoms were absent or atypical (see Table I). From this experience it has been suggested that the community’s mortality rate for a first heart attack is about 30%. About 53% of infarcts were recognized as such and survived; but 38% went unrecognized and never even came within the purview of the medical profession.

These figures lead to two important conclusions: 1) since less than one-third of deaths occur in the hospital, further improvements in hospital management of these patients (beyond the presently practiced aggressive management of intensively sought arrhythmias) is not likely to improve our mortality statistics very much; 2) since almost 40% of heart attacks never get medical attention (more than half because they die too soon), prevention is our principal hope of ever affecting this number.

Pathology of Coronary Disease

Since myocardial infarctions are due to the underlying disease of coronary arteries, prevention depends upon reducing the severity of that disease which, in more than 95% of instances, is atherosclerosis, a disease of the arterial intima. This disease process occurs in all the major arteries of the body to varying degree, and we need not go into the question of differences that may exist between the coronary arterial tree and other arterial beds, except to acknowledge that these differences are less striking and probably less important than the similarities.

The pathology of this disease process, which involves a fatty infiltration of the arterial intima, was well described over 100 years ago by the great Viennese and German pathologists who recognized the general ubiquity of the process and the means by which it could produce symptoms in many organs including the heart. They pointed out that the local fatty infiltration just beneath the inner lining could grow in size and expand until the lumen of the artery was so compromised that the flow of blood was reduced



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Table I
Incidence of New Myocardial
Infarction in the Framingham Study
Over Seven Years (Population 5,127)

	Totals	%#	%*
Total Myocardial Infarcts (ECG)	73	100	78
Clinical recognized (9 fatal)	58	79	62
Clinically unrecognized (8 no Sx.)	15	21	16
Sudden Death	20	—	22

#Excluding patients with "sudden death"
*Including all patients with "sudden death" as having myocardial infarction
(From Stokes and Dawber: *Ann. Int. Med.* 50:1359(1959))

Table II
Dietary Factors Other
Than Lipid Factors Which
May be Important in Atherosclerosis*

1. Simple carbohydrates (sucrose, fructose)
2. Complex carbohydrates (pectin, carogeenin)
3. Alfalfa factor (saponin)
4. Chow factor (roughage, lignin, soy meal)
5. Peanut and cocoa factors
6. Water factor (cadmium, calcium, chromium)

*After A. N. Howard: *Recent Advances in Nutrition and Atherosclerosis, "Atherosclerosis." Proceeding of the Second International Symposium (R. J. Jones, Ed.) p. 408, Springer-Verlag, New York/Heidelberg, 1970.*

and stagnation itself might allow the formation of a blood clot or thrombus. A debate developed then, which is still going on, as to whether arterial thrombosis may be a factor in the earliest stages of the disease or only as the terminal event.^{4,5} Because the fatty degeneration leads to a central core of necrosis, not unlike a common abscess of the skin, the atherosclerotic plaque may become centrally soft and weak, allowing rupture of a nearby capillary with hemorrhage into the plaque or allowing rupture of the atheroma into the lumen of the artery itself. This last we now know is a common event leading to compromise of the artery by clot formation which may grow to occlude the lumen at the site of rupture.⁶ The degenerated amorphous atheromatous material extruded from the "abscess" may itself be carried downstream and occlude smaller branches of the same artery.⁷

While we don't know the detailed sequence of events that go into the growth of this early atherosclerotic plaque from its first appearance as a fatty streak on the wall of the artery until its rupture with clot formation and obstruction of the artery, it is obvious that we might gain a great deal if we could prevent the appearance of that first initial lesion or even if we could limit its growth prior to the point of tissue death and "abscess" rupture. There is even some experimental evidence that the lesion can be made to regress under some circumstances.⁸ The question then becomes: what may we do toward prevention or mitigation of this process?

Risk Factors

The Framingham Study, after 14 years of observation, has shown that the risk of developing coronary disease in their population of 5,217 men and women between 35 and 65 years of age could be related to several individual characteristics: high serum cholesterol; elevated blood

pressure; increased body weight; male sex; the presence of diabetes mellitus; a family history of heart attacks; or a cigarette habit. All seemed to enhance the likelihood of developing a new stroke, myocardial infarction, or the anginal syndrome.⁹

Although men are much more prone than women to develop coronary disease (under 40, the ratio is 20:1), both sexes are vulnerable after 50 and achieve an equal risk in the 70's. If a male has diabetes mellitus or a family history of coronary disease, there isn't too much his doctor can do about it except to pay attention to the other four risk factors which are perhaps more potent pathogenetically than these two and, at the same time, more susceptible to treatment. A proper diet will allow him to lose weight; he can give up cigarettes; and there are medicines for lowering blood pressure. The most interesting relationship, and the one most potent in younger men, is the relationship to serum cholesterol level. We have drugs which are able to lower this, too, and in a short while now, the USPHS supported Coronary Drug Project may be able to tell us just what can be accomplished by drugs,¹⁰ but the more physiological approach may be through diet alone. It seems to be true that, with few exceptions, the blood cholesterol level correlates very well with the diet of a given population.¹¹

Diet and Atherosclerosis

Historically, it was a military doctor working in the Army of the Czar at the turn of the century, Ignatkovsky, who was first impressed with the great difference in prevalence and severity of atherosclerosis seen at autopsy in officers of that Army as compared with enlisted men. As he considered the differences between the life of the officers, who were drawn from the nobility, and that of the enlisted men, who were from the

poorer classes, he concluded that the greatest difference was in their habitual diets. The most striking difference was in the amount of meat eaten by these two groups, so protein was at first incriminated. Animal experiments, however, with proteins added to the diet, failed to consistently reproduce lesions.

A few years later, Anitschkow, another Russian who was familiar with these experiments, was fortunate enough to select the right experimental animal and the right dietary parameters. In a series of feeding experiments, with Chalatov, he was able to show that it was dietary fat (which generally varies directly with the protein) which was capable of producing atherosclerotic lesions in the large arteries of the rabbit; and that it was possible to produce lesions which closely resembled the human lesion by adding 2% cholesterol to an otherwise innocuous diet.¹² These experiments have been repeated with variations many times, many places and it is now possible to say that the intensity of such experimentally induced atherosclerosis varies directly with the height of the blood cholesterol and this is proportional to the levels of dietary fat and cholesterol. With varying degrees of difficulty, similar experimental lesions have been produced in many other species of animal.¹³

Cholesterol is a fatty alcohol containing the cyclopentenophenanthrene ring structure. It occurs in every animal cell. We can never hope to rid our bodies of it and, in fact, this would be undesirable. Furthermore, it will be present in any animal products we might consume, but richest in the animal fat portion, the egg yolk and the cream. Beta sitosterol is an analogous fatty alcohol that probably serves an equivalent function in the plant world in stabilizing cell membranes. It differs from cholesterol in having an additional ethyl group on the side chain. One very interesting proof of the great selectivity of the mammalian gastro-intestinal mucosa is the fact that it can distinguish between cholesterol and sitosterol, allowing absorption of the former but less than 2% of the latter.¹⁴

The relationship of diet to the disease process is not a direct one: it is thought to operate through its effects upon the blood level of cholesterol. Not only is this based upon the above experimental evidence, but also upon the fact that the blood fats, including cholesterol, occur there in about the same proportions as in the diseased artery wall.¹⁵ Furthermore, statistics, from the town of Framingham, Mass., and similar studies, suggest that the incidence of new disease in the human rises in direct correlation with

the blood cholesterol.⁹ Finally, certain people are born with cholesterol levels 2 to 4 times the normal level and have much more premature and severe arterial disease than the rest of us.¹⁶ Thus, it has been tentatively considered that what makes the blood cholesterol level go down may slow up the disease process—if to a low enough level, perhaps reverse it.

In early experiments on humans it soon became apparent that varying the dietary cholesterol intake over a wide range of 200 to 2000 mgms/day seemed to make little difference in blood levels.¹⁷ Furthermore, dietary cholesterol intake is not significantly different between men and their relatively immune wives, and their serum cholesterol do not correlate, which some authors advance as an argument for the hereditary basis of the serum cholesterol.¹⁸ Furthermore, patients who suffer heart attacks do not fall into a separate group of high cholesterol-eaters, although their blood cholesterol levels do tend to run a little higher than men of the same age not so afflicted, which is in agreement with the Framingham data. It has become apparent that the blood level of cholesterol is more susceptible to influence by the quantity and quality of fat than by the cholesterol level in the diet.

A great deal of evidence has accumulated in

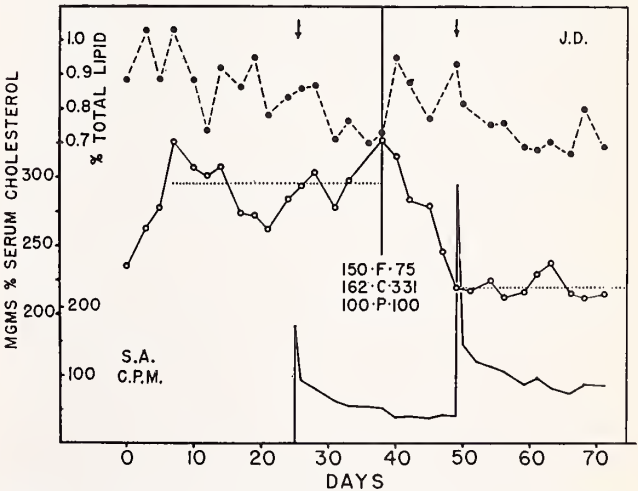


Figure 1: Dietary experiment in a 26-year-old healthy student. Two periods of 38 days each are portrayed in tandem, the dietary constituents during each half of the experiment are indicated in grams per day alongside F (fat), C (carbohydrate) and P (protein). Cholesterol intake was equal throughout and all fat was derived from animal fat. The upper curve (---) indicates serial total serum lipid determinations, the middle curve (0—0) serum cholesterol determinations and the lower curve (—) serum cholesterol specific activity in response to equivalent tracer doses of intravenous ¹⁴C acetate during the high and low dietary fat periods. The dotted lines indicate the mean level of serum cholesterol for each dietary period.

animals and men to show that the blood cholesterol falls on a fat-free or a low-fat diet, cholesterol absorption and reabsorption from the bowel being dependent upon dietary fat level. As an example, a study of our own¹⁹ was carried out in young men in which the diet included only animal fat and in which an attempt was made to keep the dietary cholesterol constant (Fig. 1). At 150 gms/day of fat in the first half and 75 gms/day in the second half of the experiment in this individual, note the sharp reduction in serum cholesterol with the reduction in animal fat intake.

Similar dietary studies in patients by Drs. Ahrens²⁰ and Kinsell²¹ and co-workers showed that, if the type of fat was changed from animal to vegetable fat or butter to corn oil, there was a similar drop in cholesterol. Even when the two fats compared were both of vegetable origin and there was no cholesterol in the diet, the cholesterol fell more dramatically with the corn oil than with coconut oil.²² The conclusion has become inescapable that the composition of the neutral fat or triglycerides of the diet is an important determinant of the blood cholesterol level.²³ The mechanism by which this occurs remains a subject for debate. Data in normal men suggest that the various fatty acids have differing potentialities for altering the cholesterol level depending upon their ability to increase the excretion of bile acids in the stool.²⁴ The bile salts, which are in fact the end-product of cholesterol metabolism, reach the bowel by way of the bile ducts. They are largely reabsorbed and reutilized in cholesterol synthesis, a small fraction being lost in the feces. If this fraction is enhanced, there is a reduction in the size of the cholesterol-bile salt pool, which is ordinarily reflected in a lower blood cholesterol level.²⁵

In studying the effects of various fatty acids in the diet upon the level of blood cholesterol of human subjects, it has developed that saturated fatty acids of all chain lengths, from lauric (12:0) and myristic (14:0) to arachidic (20:0), seem to elevate the blood cholesterol. Monounsaturated fatty acids like palmitoleic (16:1) and oleic (18:1) acids, seem to have little if any effect one way or the other. The double-unsaturated linoleic (18:2) or quadruple-unsaturated arachidonic (20:4) have cholesterol-lowering properties.²⁶

Incontrovertible as the effect of carbon chain saturation seems to be, we cannot forget that the sterol component is also important. Connor and co-workers²⁴ showed that in several men the blood cholesterol varied significantly with a re-

duction in cholesterol intake, when the fatty acid composition and other parameters of the diet remained the same. Furthermore, a large series of human experiments have now shown a rise in serum cholesterol with increasing dietary cholesterol, the basic serum level on a cholesterol-free diet depending upon the source of the fat.²³ Furthermore, the sterol content of the diet may be reflected in the total body pool or the artery wall content of cholesterol more substantially than is indicated by its influence on the blood level.

It proved to be fortunate that the cholesterol blood level can be controlled by controlling the type of dietary fat, for a line of evidence developed that suggested that possible undesirable effects might follow a simple low fat diet. For example, in one experiment at the Rockefeller Institute,²² changing the diet from a low to high level of corn oil did not lower the blood cholesterol further, but made it rise a bit. More dramatic was the rise in plasma triglyceride level. Like cholesterol, triglycerides occur in the blood and in all natural animal fats. They may have atherogenic potential equal to or greater than cholesterol.²⁷ Further discussion might review the possible importance of total caloric intake and several other non-lipid components of diet listed in Table II, which also have effects on blood cholesterol.²⁸ However, most people now agree that the quantity and quality of dietary fat are the most important determinants of human blood cholesterol and, probably, by extrapolation, coronary arterial disease.

Secondary Prevention Trials

We know that we can lower the blood cholesterol about 20 to 40% by reducing the level of animal fat and, perhaps, adding some polyunsaturated fat in the form of corn or safflower oil. Several studies have set out to see what difference this rather benign diet could make in the highly unpredictable course of coronary artery disease. Two studies are worthy of attention. Both are studies in secondary prevention—i.e. preventing the second attack after the patient has already suffered one heart attack. The advantage in such a study is that fewer patients are needed to evaluate treatment: it's a very high risk group and, if the second heart attack can be prevented in a fair proportion of the group—say 25%, its size need only be 200 or 300 patients followed for 5 years. To achieve the same objective in a primary study (using healthy middle-aged men) would require 50,000 to 200,000 men and \$2-50

million a year for five or more years, depending upon the design of the trial.²⁹ Such a trial may ultimately be necessary because of the obvious disadvantage of a secondary prevention study: once symptoms have finally appeared it may be too late in the course of the disease; and the arterial lesion has already advanced too far to expect a very great effect of diet upon the subsequent course of the disease.

Dayton and Pearce studied a population of veterans living in a V.A. domiciliary care unit in Los Angeles;³⁰ 846 men volunteered for the study; half were given a diet containing supplements of vegetable oil, a limited number of eggs per week and lean cuts of meat. This contrasted with the others who stayed on the conventional American diet in which 40% of calories were derived from fat, almost all animal fat. These men were then carefully observed medically and the benefit of the diet determined. Even though the average age of these men was 65 years, there was a definite difference noted in favor of the dieting group after eight years. The experimental group had a lower cholesterol level (13%) than the control group for most of these years, although both fell from their initial levels. The tabulation of deaths showed that proven myocardial infarctions, strokes and sudden death, when lumped together in combination as acute atherosclerotic events, occurred more often in the control group than the diet treated group, even though these two groups were found to be comparable in almost every other parameter studied. This study included a fair number of men older than 65 years and 30% had definite evidence for pre-existing arterial disease. That any significant difference could be found at all was remarkable, but the results were clouded by the fact that, in spite of the apparent improvement in vascular disease, morbidity and mortality in the dieting group, overall mortality rates were not significantly different between both groups.

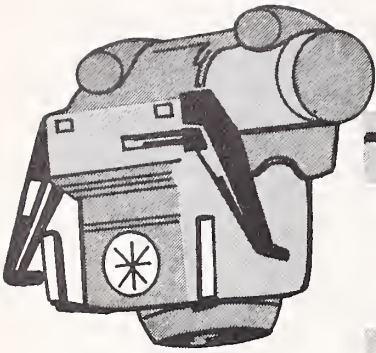
Leren of Oslo performed a more "pure" study in secondary prevention, using 408 male patients who had survived a heart attack.³¹ These patients were randomly divided into two groups: one-half continued on their usual high fat diet; and the other half pursued a diet low in animal fat, free of eggs and supplemented with vegetable oil. The experimental group showed a substantial and continuing reduction in serum cholesterol. When their subsequent course was observed, the incidence of recurrent myocardial infarction and new episodes of coronary insufficiency in five years of study were almost halved in those patients under 60 years. Sudden death was

not reduced but was even more common in the diet group. Thus, although the recurrent heart attack rate in the two groups was significantly different after 3 years and continued to diverge for the 4th and 5th years, the over-all mortality rate was not significantly different in 5 years.

These two studies have exemplified the best in large scale studies of secondary prevention of coronary disease. There are several less well-controlled studies, not all of which support the notion that heart attacks can be prevented by pursuing a blood cholesterol-lowering diet.³⁰ Even so, why don't we reorder the American diet on the reasonable charge that we can perhaps cut the rate in half for complications of coronary disease? There are certain caveats which must be remembered and which require that the primary prevention study mentioned above be carried out:

1. Not only are there commercial interests that would like to encourage greater consumption of meat and dairy products, but the quasilegal definitions of milk, cream, cheese, etc. depend upon fat content. In fact, cost is generally tied to fat content by long tradition. There is some reluctance in commercial and legal quarters to make a change in these arrangements until we have proof positive. It should quickly be added that the food processing industry is not totally resistant to accepting changes. Low fat ice cream, vegetable oil margarines, non-dairy cream substitutes, skimmed milk products, etc., have been made increasingly available in our supermarkets, if not our restaurants.
2. While there is the general correlation indicated between blood cholesterol, heart attacks and group diets, there are many individual exceptions: some patients with quite low cholesterol levels still succumb. The protagonists contend that all Americans have too high a cholesterol and that a true normal for humans is about two-thirds the American average of 240—equal to the African or Indian average: this is not established.
3. Heart attack frequency correlates with income and responsibility as well as with diet and it is very difficult to exclude the possibility that diet is not really the crucial factor. Something else in our way of life—e.g. "stress" or too sedentary an existence—may be *the* factor. This has been neither established nor excluded.

(Continued on page 156)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

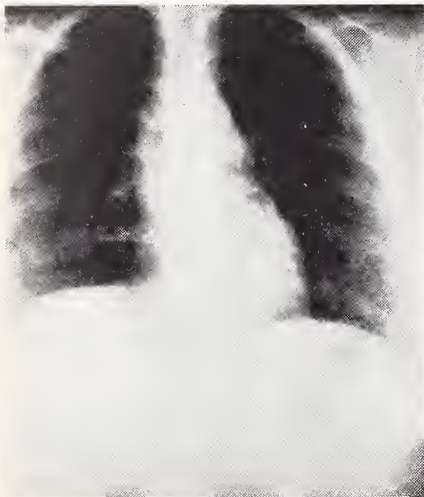


Figure 1



Figure 2

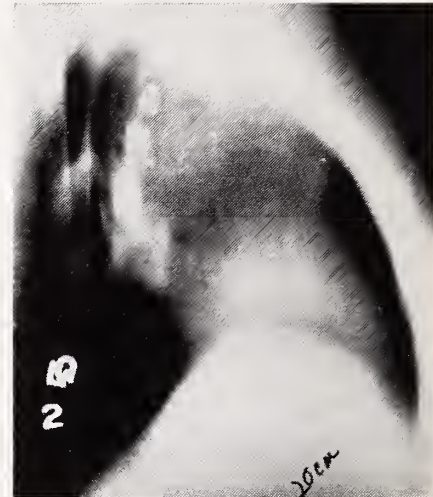


Figure 3

This is a 36-year-old female who entered the hospital because of uterine bleeding. In the course of a routine pre-operative work-up a chest film was obtained. (Figures 1, 2, 3)

What's your diagnosis?

1. Teratoma
2. Metastatic lymph node enlargement
3. Lymph node enlargement resulting from lymphoma
4. Thymoma

(Answers on page 133)

Multiloculated Cystadenoma of the Liver

BY FREDERICK J. MERCHANT, M.D./CHICAGO

Since the original description of a solitary non-parasitic hepatic cyst in 1856 by Michel titled "Kyste de la face posterieure du foie" in *Gaz d. hop*¹ more than 300 similar cases have been reported. Nonetheless, there is still disagreement as to a precise definition of what constitutes such cysts. Presented is a case of a non-parasitic hepatic cyst to remind the clinician of its possible occurrence in the patient with a liver mass and protean signs and symptoms.

Case Report

This 27-year-old woman was being followed by the University of Illinois Clinics for idiopathic cerebellar ataxia. In April, 1971, she was admitted for chills, fever, right-sided pleuritic pain and hepatomegaly. A liver scan was obtained (Fig. 1) because of increasing hepatomegaly and right upper quadrant tenderness. As these symptoms progressed over the next several days, a second liver scan (Fig. 2) was obtained which strengthened the diagnosis of liver abscess. An extensive work-up failed to completely settle the diagnosis. A course of antiamebic therapy did not improve the patient. In June, 1971, an exploratory laparotomy revealed a large glistening hepatic cyst consistent with a cystadenoma.

Approximately 700 ml. of bloody fluid were aspirated from the cyst. The cyst wall was biopsied, microscopic examination of which confirmed the diagnosis. Multiple penrose tubes and a large sump catheter were used to drain the cyst and remaining hepatic tissue. The patient recovered and improved over the next two weeks. Recurrent hepatomegaly required re-exploration which showed increasing cyst size, necessitating a right hepatic lobectomy. Three weeks following the second laparotomy, the patient succumbed to liver failure.

Discussion

The etiology of non-parasitic hepatic cysts is still unsettled. Moschowitz in 1906, basing his ob-

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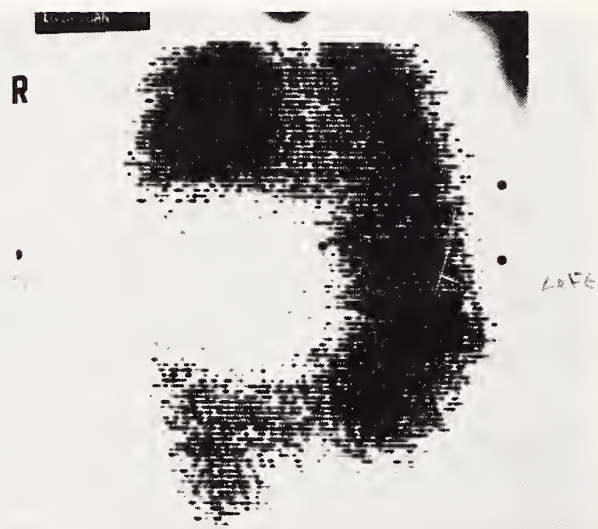


Figure 1: Liver scan showing anterior view of large hepatic filling defect approximately 10 x 20 cm. in size.

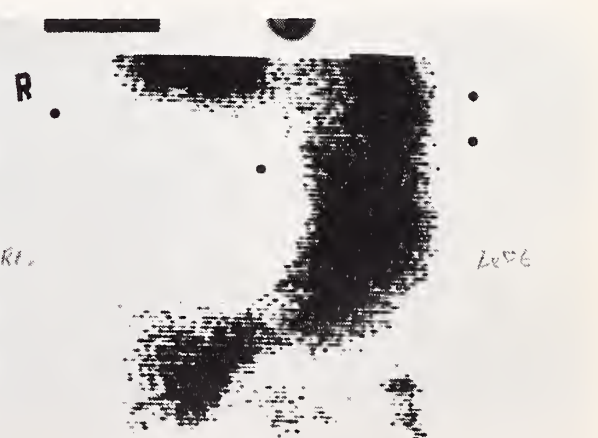


Figure 2: Liver scan repeated in five days showing enlarging right hepatic filling defect.

servations on 85 patients, concluded that these cysts were congenital and arose from aberrant intra- and extra-hepatic bile ducts. He maintained that cyst formation was caused by hyperplastic changes stimulated by inflammatory reactions or by ductal obstructions.²

Anatomically these cysts vary in size, most of them ranging in diameter between 1 and 15 cm., with the largest reported in the literature as containing an estimated 17,000 ml. of fluid. These cysts may be either unilocular or multilocular,³ as in our case. In one study for example of 197 solitary cysts only 20 were multilocular. The external surface of the cyst is usually smooth and glistening with a bluish hue and may show tortuous dilated veins. The wall varies in thickness but is seldom greater than 8 mm.

Histologically the wall is composed of three microscopically distinct layers: an inner layer of cuboidal or columnar epithelium, a middle layer of vascular elements, and an outer layer of collagen, some muscle fibers, bile ducts and compressed hepatic cells.

According to a study by Eliason and Smith in 1944, only 28 cases of cystadenomas were found in 20,000 consecutive autopsies and of the 211,046 hospital admissions, only 2 cases were found before death. These observations make cystadenomas extremely uncommon.⁴

The oldest reported patient to have such a cyst was a 90-year-old woman and the youngest patient a 4-day-old infant. Additionally, the same kind of cyst has been found twice in the human fetus.

Physical signs are variable. A distended abdomen and a palpable fluctant mass are the usual findings. Rarely the cyst may be palpable during the pelvic examination. Routine laboratory values usually do not vary much from normal. Roentgenologic examinations are not usually diagnostic but may show: (1) filling defects on scans, (2) elevation of either diaphragm, (3) abnormal soft tissue densities, (4) displacement of the stomach, gallbladder, duodenum, colon or right kidney, (5) duodenal or antral obstruction and (6) right hydronephrosis or hydroureter.

Correct preoperative diagnosis is a rarity because of the infrequency of the lesion and its multiplicity of signs and symptoms. Complications of an undiagnosed cyst include spontaneous rupture into the free peritoneal cavity, torsion on its pedicle, hemorrhage into the cyst and infection. There has been no report of malignant degeneration occurring in polycystic liver disease.

The treatment of choice of solitary non-parasitic cysts is complete extirpation which is ideally achieved by enucleating the cyst from its hepatic bed. Marsupialization of the cyst to the peritoneum and internal drainage to the stomach or a Rouxen-Y anastomosis has also been used. A fenestration procedure has been described for polycystic livers in which communications are made for drainage among the cysts. In cases of large cysts, partial excision and packing the remaining liver bed with gelfoam or oversewing the bed with an omental tampon has been tried.⁵

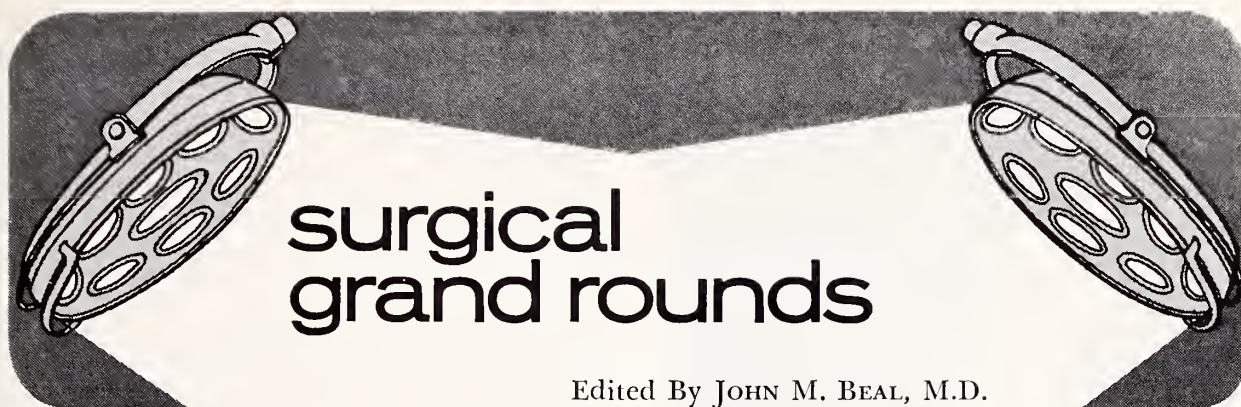
Operative mortality has been approximately 2.5%. The greatest morbidity is usually encountered with complications of subphrenic abscess and recurrence of the cyst. With recurrences, the period of time elapsing from the time of initial surgery to that of recurrence may vary from 25 months to 28 years; thus, these cysts recur generally at a fairly slow rate of growth.

Summary

The case of a 27-year-old female having a cystadenoma of the liver is reported. At the first laparotomy, surgical drainage of the cyst was performed. A second surgical exploration resulted in complete resection of the lesion. This lesion has proven to be very difficult to diagnose preoperatively, having been so reported in the literature only nine times. Present surgical approaches indicate that extirpation of these cysts offers the best chance for cure. ◀

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Gas Infection of Thigh

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Passavant Pavilion, Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 17, 1972.

Case Report

Dr. Robert Ward: A 54-year-old man was admitted to the Northwestern Memorial Hospital on October 7, 1972, with the chief complaint of pain in the lateral aspect of the left thigh of one week duration. The pain began in a localized area in the upper left lateral thigh and gradually extended down to the left knee. Past medical history includes a diagnosis of lymphosarcoma established 10 years earlier, which had been treated with irradiation followed by intermittent courses of chemotherapy. Six weeks before this admission, Cytosan 500 milligrams once a week and Prednisone 15 milligrams was administered t.i.d. In addition, hospitalization had been required one and a half years ago for suspected diverticulitis. At that time, a barium enema demonstrated diverticula in the descending and sigmoid colon. At the time of the present admission, the patient denied any history of trauma, fever, chills or gastrointestinal symptoms.

Physical examination revealed a well-developed, well-nourished white male without acute distress, but unable to walk because of pain in the left hip. Blood pressure was 112/80; pulse was 88 and temperature was 100.4° F rectally. Pertinent physical findings were limited to the left lower extremity which showed tenderness over the upper aspect of the left lateral thigh.

Admission laboratory data included a white blood cell count of 8,400 with a marked shift to the left. Urinalysis, serum BUN, electrolytes and sugar were normal.

The patient's hospital course consisted of rapid progression of the inflammatory process. Three days after admission, surgical consultation was obtained. At this time, there was swelling and tenderness of the entire left lower extremity with crepitation from the groin down to the mid calf. An area of tenderness and crepitation was also present in the upper right lateral thigh. X-rays of the pelvis and both thighs were obtained.

Dr. Harold Matthies: X-rays of the left thigh show a normal femur; there is an accumulation of gas in the soft tissue, dissecting the soft tissue and accumulated under the skin (Figure 1). A film of the hip also shows soft tissue dissection and accumulation of gas. A lateral view of the knee demonstrates dissection of the soft tissue by this gas forming organism.

Dr. Robert Ward: Aspiration of subcutaneous fluid was performed above the left knee and smear of this material revealed gram-positive cocci and gram-negative rods. The patient was taken to the operating room and multiple fasciotomies were performed. There were three incisions made on the lateral aspect of the left lower extremity with a break in continuity at the



Figure 1: X-ray of left thigh demonstrates gas in the soft tissues.

knee. Fasciotomies were performed also on the medial aspect of the left thigh and on the lateral aspect of the right thigh. At the time of operation, thin watery fluid was released, particularly from the left lateral thigh incision. The exposed muscle appeared normal. Culture of the fluid yielded gram-negative rods which were identified as *Proteus* and *E. coli*. The patient showed clinical improvement during the next four days; however, five days postoperatively, feces was noted in the upper end of the left lateral thigh incision. On the following day, a right transverse colostomy was performed. One week later, a barium enema was obtained.

Dr. Harold Matthies: As soon as the barium was introduced, extravasation became apparent. The extravasation has its origin in the sigmoid colon and may be seen to extend toward the region of the left hip. This has the appearance of a larger peri sigmoid abscess. The barium enema also demonstrates a number of diverticula (Figure 2), so that the abscess and fistulous tract is probably due to diverticulitis. Later in the examination, a second fistulous tract was seen extending to the right.

Dr. Robert Ward: Plans for this patient include delayed primary closures of the fasciotomy

incisions and elective resection of the sigmoid colon after at least three months has elapsed. Closure of the colostomy was to be performed.

This patient illustrates an unusual complication of diverticulitis and, in addition, presents many of the problems of infection from gas-forming organisms. Regarding the first point, fistula formation as a complication of diverticulitis is well recognized and reportedly occurs in one-fifth of the patients who have diverticulitis, either as a complication of the primary disease or following surgical intervention. The most common type is colovesical fistula, but this is followed closely in frequency by colocutaneous fistula. Colocutaneous fistulas are the result of surgical procedures performed for the treatment of diverticulitis. The reported incidence is approximately 6%. In general, these fistulas drain to the anterior abdominal wall, but have been reported in the thorax, the buttocks, the lumbar region, the thighs, the perineum and perianal regions. In a review of the literature, reports of only three patients were found who developed a colocutaneous fistula into the thigh.

Dr. John Beal: Dr. Boris Reisberg has been asked to discuss problems associated with treating infections from gas-forming bacteria.

Dr. Boris Reisberg: The interesting thing is that the majority of cases of cellulitis involving the skin and subcutaneous tissue associated with the presence of gas are not due to clostridial infection, but due to the presence of enteric bacilli. I think the physician's immediate reaction is the possibility of clostridial infection, when con-



Figure 2: Barium enema examination discloses fistula which originates in sigmoid colon.

fronted with this kind of problem, namely gas cellulitis. This disease usually presents as a fulminant infection with early destruction of muscle—not present in our patient, and necrosis of the overlying skin and subcutaneous tissue. Gas is usually present and the patient complains of severe pain. The skin frequently takes on a bluish-purple discoloration and hemorrhagic blebs appear.

A gram stain of aspirated material will reveal gram positive rods and a presumptive diagnosis of clostridial gangrene. Strict anaerobic cultures are required for final identification and speciation. When clostridial gangrene is associated with toxin production, a lecithinase, there is rapid hemolysis of red blood cells, a dramatic fall in hematocrit, and frequently renal failure. This is probably secondary to the deposition of hemoglobin in the kidney tubules and the adverse effects of hypotension.

As I have stated previously, the most frequent cause of gas cellulitis is infection produced by enteric gram negative bacilli. The most common of these to be isolated from such infections are *Proteus mirabilis*, *E. coli*, *Klebsiella* and *Enterobacteria* species. These organisms are capable of metabolizing a variety of sugars, including glucose, with the production of gas. Since these organisms are present in the stool and gastrointestinal tract as part of the normal flora, it is easy to see how infection was produced in our patient following a perforated diverticulum. These organisms also are present on the skin in the perineal area and breaks in the skin in this location may be contaminated with fecal flora and gas cellulitis produced in this manner.

Not infrequently, a synergistic necrotizing cellulitis, with gas production is the result of infection caused by the presence of anaerobic streptococci, *Bacteroids*, or both in combination with one of the usual enteric gram negative bacilli. Recognition of this condition, which carries with it a high mortality, is dependent on adequate anaerobic cultures as well as the routine aerobic cultures. Antibiotic therapy here must be directed against both the aerobic gram negative rods as well as the anaerobic organisms. Unfortunately, antibiotic therapy alone is inadequate in the treatment of these patients and good surgical debridement must be carried out. In our patient presented, both *E. coli*, *Proteus mirabilis* and a microaerophilic streptococcus were isolated from his infection, so I feel he would fit into this latter category of synergistic necrotizing cellulitis. Perhaps with the improved anaerobic cultural

techniques available today, all cases of gas cellulitis thought previously to be due to aerobic enteric bacilli alone, will be found to be mixed infections.

Dr. John Beal: Dr. Reisberg, do you think that his other disease, lymphosarcoma, and the chemotherapy played a role in this picture?

Dr. Boris Reisberg: Probably. It's hard to say. His lymphosarcoma has been fairly well controlled, but he has a defect in host defense which prevented the containment of the single perforated diverticulum.

Dr. John Beal: Dr. Hines, at the time of surgery, if you were convinced that there was no muscle necrosis and you were fairly sure that there were no clostridial infection, would that have limited the extent of the fasciotomy?

Dr. James Hines: No. We did the fasciotomy where the infection existed, in both thighs, around the left knee and joint and down below the left calf. We considered performing a colostomy at the time of the first operation. While there were no abdominal findings (probably suppressed by the steroids), we thought that this infection stemmed from diverticulitis. Indirect evidence pointed to the colon and we felt that we should go ahead and do a colostomy at that time. He improved for about three days; but, where feces drained from the hip wound, we did the colostomy. ◀

View Box

(Continued from page 128)

Diagnosis: Lymph node enlargement resulting from lymphoma. This form of Hodgkins disease has a strong tendency to involve the anterior, mediastinal lymph nodes as well as the lymph nodes in the middle mediastinum. Actually, it would be almost impossible to make a differential diagnosis in this case from a thymoma as there appears to be a fairly homogenous mass which involves the anterior and middle mediastinum and seems to be intimately associated with the heart and great vessels. At surgery, there was diffuse lymph node involvement as well as invasion of the thymus by Hodgkins disease. The anterior mediastinum is the most common site of mesenchymal neoplasms, intrathoracic thyroid and parathyroid hyperplasias and neoplasms and of course thymomas. ◀

Repeated Bouts of Pneumonitis Cough with Feedings and Abdominal Distention

BY HUGH V. FIROR, M.D., F.A.C.S., F.A.A.P./CHICAGO

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. Initially, the series will be based on patients seen by the editor at the Cook County Hospital, Division of Pediatrics. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Case Reports

Baby A: A four-month-old first born baby boy is admitted with his fourth episode of pneumonitis. Birth weight was 6 lbs. 8 oz., weight now is 7 lbs. 12 oz. His mother states that with some feedings he coughs and turns blue. The mother's sister, who has three children, commented that the baby's tummy was "too big."

Little Girl B: A three-year-old girl weighed 14 pounds; she had constant respiratory trouble and a distended abdomen. She was operated upon at two days of age for an esophageal atresia and re-operated 10 days later. Past records are not available. She has literally lived on antibiotics for "chest congestion;" her abdomen remains grossly distended and tympanitic; she eats solids easily but occasionally chokes with liquids. X-rays done elsewhere are said to be normal and a diagnosis of malabsorption was suggested.

Both of these children have a serious but frequently elusive lesion. The baby boy has a tracheoesophageal (T-E) fistula without esophageal atresia, an unusual lesion which accounts for but 3-4% of congenital anomalies of the up-

per esophagus.¹ Little girl B has a fistula which recurred following repair of an esophageal atresia with T-E fistula. This complication follows such surgery in as high as 11% of cases.²

Recurrent episodes of pneumonitis most frequently presage this diagnosis. Cough, choking spells, or cyanosis provoked by feeding vary in intensity with the size of the connection, but are frequently present. The forceful passage of air through the abnormal connection during crying produces the chronic abdominal distention. Prominent findings such as these commonly provoke the making of varied erroneous diagnoses.

Anatomically the isolated T-E fistula usually occurs higher than the fistula which accompanies esophageal atresia allowing the surgical approach to be made through the neck.³ The tracheal end of the fistula is commonly higher than the esophageal end; hence the designation "H" type fistula might more appropriately be termed "N" type. The post operative recurrent fistula is lower and must be approached through a chest incision.

Diagnosis requires that the lesion be suspected and that efforts toward confirming this clinical suspicion be persistent. An esophagogram is part of the work-up of a baby with any combination of the symptoms and findings mentioned. Careful fluoroscopy with the baby prone may demonstrate communication of the esophagus with the tracheo-bronchial tree (Figure 1). A repeat examination with cine techniques may succeed if the

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Figure 1: Esophagogram demonstrates barium passing through reformed fistula between levels of 3rd and 4th ribs. Higher up at level of 1st rib there is a streak of contrast material in the trachea.

initial examination is negative. Endoscopy has had a poor batting average in confirming this diagnosis. Observing the upper esophagus through an esophagoscope while methylene blue is dripped through an endotracheal tube may allow diagnosis by noting the dye to appear in the esophagus.^{2,3} Using newer endoscopic equipment Gans has reported identification of this lesion in several infants by endoscopic inspection alone.⁴ With similar equipment Johnson has identified

and cannulated the fistula with a ureteral catheter to facilitate its identification at subsequent surgery.⁵

If the clinical picture fits this lesion diagnostic efforts must be persistent until the lesion is identified or another definite explanation for the symptoms is defined. Untreated, this lesion carries a high morbidity and mortality. Chronic pulmonary sepsis, destroyed lung, failure to thrive and eventual death all occur when this lesion persists uncorrected.

Defining the location of the fistula determines the appropriate operative approach. The presence of severe pulmonary disease may make immediate surgery unduly hazardous, or pulmonary disease may be severe and although the clinical picture is suggestive the fistula may defy initial efforts at identification. In either of these two situations the performance of a gastrostomy, which is kept on constant drainage, will protect the lungs and aid in efforts at clearing up pulmonary infection in preparation for either surgery or for more diagnostic studies. Nutrition can be maintained by central venous alimentation or through a silastic jejunostomy feeding tube placed at the time of performance of the gastrostomy.⁶

When the diagnosis is made, the level of the communication defined and the pulmonary infection adequately controlled, surgery is undertaken. A cervical approach is the choice in all but the exceptionally low placed isolated fistula. The fistula which is recurrent after esophageal repair is approached through the chest. It is desirable to divide and oversew the fistula rather than to ligate it.

Recanalization of the fistula less commonly occurs if division and suturing are carried out. This also allows a flap of fascia, muscle or adventitia to be interposed between the suture lines further insuring that the closure will be permanent.

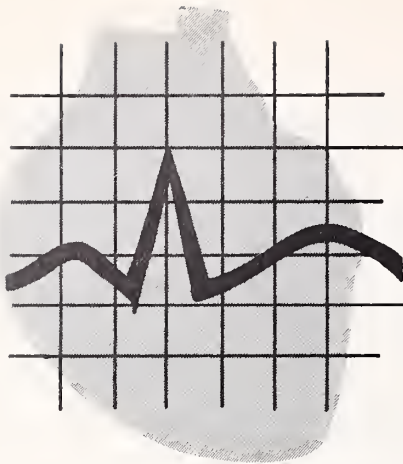
Points for Re-emphasis

Recurrent pneumonitis with coughing; choking or cyanosis provoked by feeding; persistent gaseous distention of the abdomen; or any combination of these makes an isolated T-E fistula a diagnostic consideration.

Diagnostic efforts must be persistent as defining this lesion may be difficult. Untreated the prognosis is poor.

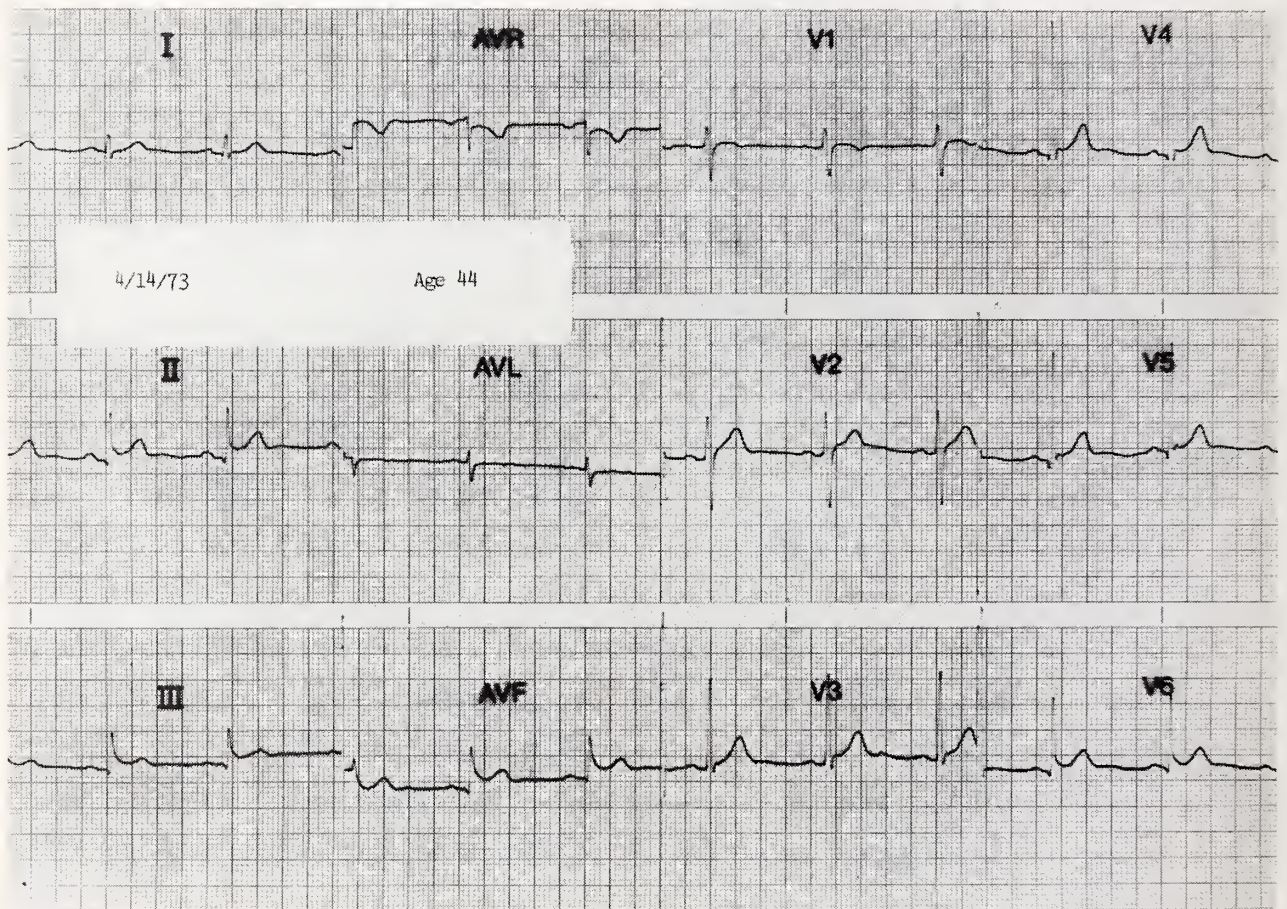
Diagnostic definition and efforts to improve pulmonary sepsis should be followed by early surgical correction. ◀

(References continued on page 157)



ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,
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A 44-year-old white businessman was seen in the emergency room complaining of recurrent left precordial pain lasting up to several hours. Physical examination was normal except for left chest wall tenderness.

Questions:

1. The electrocardiogram taken in the emergency room shows:

- Acute inferolateral wall myocardial infarction
- Acute pericarditis
- Electrolyte imbalance
- Myocardial ischemia

e. None of the above

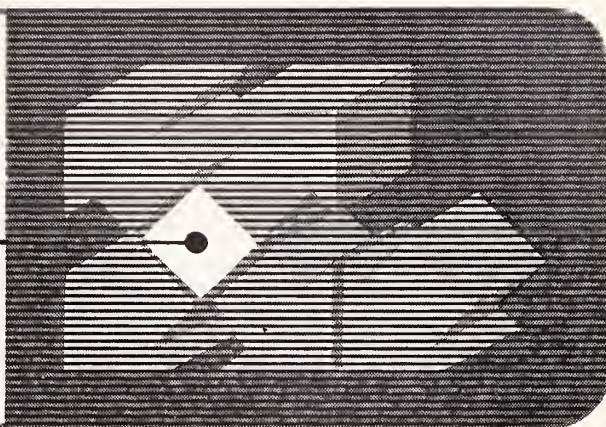
2. The following clinical course was most likely:

- Patient developed complete A-V heart block
- Serial serum enzymes showed elevation with gradual return to normal
- Pain was relieved with aspirin and diazepam
- Serum potassium on admission was 2.1 mEq/L
- None of the above

(Answers on page 157)

Trauma Center

DAVID R. BOYD, M.D.C.M., Editor



A Statewide System For Post-Traumatic Renal Failure

BY GEORGE DUNEA, M.B., M.R.C.P./CHICAGO

A quarter of a century after the invention of the artificial kidney, the problem of acute renal failure remains unsolved. Formerly death was inevitable, but with the development of modern methods, the mortality has been reduced to about 50%. The outlook is excellent when acute renal failure results from obstetric complications, urinary tract obstruction or from uncomplicated necrosis due to nephrotoxins. By contrast, less than half the patients survive in renal failure that follows surgery, trauma or severe infection. Recently Lordon and Burton reviewed their experience in 67 cases of post-traumatic renal failure occurring in Vietnam casualties and reported a mortality rate of 63%.¹ Even higher mortality rates, ranging from 70-90%, have been reported following biliary and intestinal surgery, and in burns.² Sepsis, gastrointestinal hemorrhage and respiratory failure remain formidable complications (Table I). The overall mortality rate has remained high, perhaps because patients are frequently older, sicker, or have had major surgical procedures that were unavailable previously.³

It is clear then that whereas uncomplicated acute renal failure of obstetric or medical origin

can usually be dealt with in a straightforward manner, a different approach is required for the post-traumatic or surgical patient. In these cases, where mortality rate may be as high as 90%, an improved survival rate requires intensive therapy in a specialized unit. The patient should be treated by a team accustomed to deal with this kind of problem and where specialists of various kinds are available to consult or become actively involved in the management of the patient.

A Statewide Approach

In order to achieve optimal conditions for the patient with severe, complicated post-traumatic renal failure, it is planned to set up a statewide educational and referral system which will guarantee prompt diagnosis and aggressive management. This statewide network will be a subsys-



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Table I

Causes of Death in Acute Renal Failure

(In Approximate Order of Frequency)

1. Septicemia
2. Gastrointestinal hemorrhage
3. Respiratory failure
4. Cardiac failure or digitalis intoxication
5. Pulmonary embolism
6. Disseminated intravascular coagulation
7. Myocardial infarction
8. Cerebrovascular complications
9. Hyperkalemia

Table II

Indications for Dialysis

1. Signs of clinical deterioration such as anorexia, nausea, vomiting, weakness, drowsiness, mental confusion
2. Overhydration, congestive heart failure, pulmonary edema
3. Ingestion of dialysable poisons
4. "Prophylactic" dialysis before surgery or in "hypercatabolic" renal failure
5. Biochemical indications of uremia (BUN > 100mg/100 ml, rapidly rising serum creatinine)
6. Acidosis (CO_2 < 12-15 mEq per liter)
7. Hyperkalemia unresponsive to conservative measures

tem of the Illinois Total Emergency Medical Services System⁴ and will utilize existing educational efforts and referral patterns for the advantage of the severely ill patient. The statewide network for referral and treatment of acute renal failure will utilize some, but not all, of the existing trauma centers. Arrangements will be made whereby problem patients may be transferred to a referral center, and returned to their original source of medical care after recovery from the acute illness.

Physician Education

The educational effort for physicians will emphasize prophylaxis of acute renal failure, treatment of emergencies, initial management and indications for transfer to a specialized renal referral center. Prevention of death from hyperkalemia, shock, hemorrhage and pulmonary edema will be emphasized; preparation of such a patient for transfer, his treatment en route, and indications for dialysis (Table II) will also be included. Special regional workshops, one half

to one day in length, will be held in renal referral center hospitals to familiarize physicians with treatment methods. Special written materials, prepared by the Division of Emergency Medical Services and Highway Safety in conjunction with specialists in renal disease, will be made available through these workshops and to other interested physicians across the state.

Nurse Education

The management and transfer of patients in acute renal failure will be made a standard part of the Trauma Nurse Training Course. In addition, one-day regional symposia on acute renal failure will be arranged by trauma nurse coordinators.

Postgraduate nurse training will emphasize the early recognition and management of acute renal failure. This includes care during transportation, the importance of daily weighing, keeping an accurate fluid balance sheet, provision of adequate nutrition and avoidance of high potassium foods, as well as the principles and practical aspects of peritoneal dialysis (Table III). Visits to renal units and, in certain instances, short periods of rotation through renal centers, will be arranged in order to make the nurse an integral and highly skilled member of the renal team.

Table III

Contraindications to Peritoneal Dialysis

1. *Relative*
 - a. Extreme obesity
 - b. Extensive abdominal trauma, surgery, infection
 - c. Postoperative adhesions
 - d. Suprapubic cystostomy
 - e. Severe hypercatabolic renal failure
2. *Absolute*
 - a. Patent opening in the diaphragm

Trauma Coordinators

The trauma coordinator will play an important role in the physician-directed renal referral system. Coordinators will serve as liaisons between the transferring doctor and the renal referral center, and will arrange transport by helicopter, fixed wing aircraft, or overland critical care vans, if regular ambulance transportation is inadvisable in the physician's opinion.

In addition, trauma coordinators will participate in the training of emergency medical technicians-ambulance and mobile intensive care per-

(Continued on page 158)

Doctor,

What Do You Know About Venereal Disease?*

Here's a quiz to help you find out

Venereal Disease, Diagnosis, Treatment and Control

(This test was written for statistical purposes only and was designed to determine the scope and adequacy of venereal disease training the new medical officers had received prior to entering military service.) **

Multiple Choice

1. With a low titred VDRL test, a patient with no clinical evidence of syphilis may:
 - () A. Have syphilis and was never treated or was inadequately treated.
 - () B. Have had syphilis and was successfully treated at some time in the past.
 - () C. Have a biologic false positive test.
 - () D. All of the above.
2. The term treponemal serologic test refers to the fact that the antigen used in the testing is either a treponeme or a product derived therefrom. One of the following, however, utilizes living organisms in the actual test. Which one:
 - () A. FTA
 - () B. TPI
 - () C. RPCF
 - () D. Kolmer
3. In determining whether or not CNS syphilis is active, the most important spinal fluid finding is:
 - () A. Reactivity of the VDRL test
 - () B. Protein
 - () C. Cells
 - () D. Colloidal gold curve

*Reprinted from *Michigan Medicine*, February, 1973.

**This is a copy of the Army VD Quiz which was submitted for publication by Col. Jerome H. Greenberg, M.D., Director of Health and Environment for the U.S. Surgeon General's Office.

4. To cover all possibly infected contacts, patients with secondary syphilis should be interviewed for sexual contacts of the past:
- ☐ A. One month
 - ☐ B. Three months
 - ☐ C. Six months
 - ☐ D. Twelve months
5. About one-fourth the patients with a primary syphilis lesion will have a non-reactive serologic test for syphilis. Therefore, the only *absolute* method of diagnosis is:
- ☐ A. History of sexual contact
 - ☐ B. Clinical characteristic of the lesion
 - ☐ C. The darkfield examination
 - ☐ D. Establish diagnosis of syphilis in a sexual contact
6. Infectious mononucleosis and syphilis may have all of the following signs or symptoms in common except:
- ☐ A. Positive heterophil antibody test
 - ☐ B. Reactive serologic test for syphilis
 - ☐ C. Low grade fever and generalized rash
 - ☐ D. Generalized lymphadenopathy
7. A woman in her third month of gestation is found to have a reactive VDRL 1:1. A search of her medical history revealed that she had Bicillin four years previously for diagnosis of latent syphilis. At that time VDRL was 1:8. At follow-up examination one year later the titre was 1:1 and all physical findings negative. The physician managing this patient should:
- ☐ A. Treat immediately to avoid congenital syphilis
 - ☐ B. Do a spinal tap
 - ☐ C. Document the adequacy of past treatment and follow carefully
 - ☐ D. Ask for a FTA-ABS
8. The most important reason for the difficulty in gonorrhea control is:
- ☐ A. At present no epidemiology is being applied
 - ☐ B. The N. gonorrhea is becoming resistant to penicillin
 - ☐ C. In females the disease by and large is asymptomatic
 - ☐ D. Diagnostic tests in the female are limited
9. The most accurate and practical diagnostic test for gonococcal urethritis in the male is:
- ☐ A. Gram stain of urethral exudate
 - ☐ B. Culture using Thayer-Martin medium
 - ☐ C. Culture using conventional GC base media
 - ☐ D. Fluorescent antibody
10. The primary lesion in lymphogranuloma venereum is an evanescent:
- ☐ A. Inguinal adenitis
 - ☐ B. Papule or vesicle
 - ☐ C. Ulcer
 - ☐ D. None of these
11. The incubation period for symptoms of acute chancroid infection in the male is:
- ☐ A. 3-5 days
 - ☐ B. 2-14 days
 - ☐ C. 7-21 days
 - ☐ D. 10-90 days

True/False

12. Darkfield examinations of the rectum and anus are not necessary and difficult because of other treponemes present in the rectum.
☐ A. True
☐ B. False
13. *Epidemiologic treatment* refers to the treatment of *bona fide* sexual contacts to infectious syphilis who may or may not be in the prodromal or incubating stages of disease.
☐ A. True
☐ B. False
14. Gonorrheal infections have been shown to be asymptomatic in 10-15% of male cases.
☐ A. True
☐ B. False
15. Initial treatment of acute gonorrhea in the female who is not sensitive to penicillin is 4:8 million units of benzathine penicillin.
☐ A. True
☐ B. False
16. Syphilis is communicable during the second stage.
☐ A. True
☐ B. False
17. Congenital syphilis results from prenatal transmission of spirochetes from mother to fetus in the first three months of pregnancy.
☐ A. True
☐ B. False
18. Chancroid is a self-limited infection.
☐ A. True
☐ B. False
19. The treatment of choice for chancroid is sulfasoxazole.
☐ A. True
☐ B. False
20. In male gonorrhea any urethral discharge three days after appropriate initial treatment means the patient should be retreated with the same regimen.
☐ A. True
☐ B. False

Match the Appropriate Number. An Item May Be Used More Than Once

- | | |
|--|---|
| A. Syphilis | 23. <input type="checkbox"/> Large, friable ulcerated areas with beefy red base |
| B. Gonorrhea | 24. <input type="checkbox"/> Purulent urethral discharge |
| C. Chancroid | 25. <input type="checkbox"/> Rectal stricture |
| D. Lymphogranuloma Venereum | 26. <input type="checkbox"/> Purulent arthritis |
| E. Granuloma inguinale | 27. <input type="checkbox"/> Frei test |
| 21. <input type="checkbox"/> Ulcer with clean base and indurated edges | 28. <input type="checkbox"/> Penicillin and Probenecid |
| 22. <input type="checkbox"/> Penile ulcer with ragged edges, dirty gray base | 29. <input type="checkbox"/> Multiple sinus tracts |
- (Answers on page 155)*



membership forum

Dear Editor:

I note with interest your editorial on "WHY GO TO MEDICAL SCHOOL" in the July, 1973 edition of the *Illinois Medical Journal*.

You state essentially the reasons for a young person to go to medical school, and then you have a second paragraph citing the reasons why they are deterred from medical training. An interesting point is the great difficulty encountered when a highly qualified applicant for medical school finds it almost impossible to get into a suitable school for continued training. An individual with a high scholastic average, high motivations, an eagerness to pursue the career of medicine, who has fulfilled all the requirements

in training for an M.D. degree, is then faced with a wild scramble for admission to medical school with no certainty that such will be accomplished. It is my feeling that this in itself is a heart-breaking deterrent to the young individuals from whom the medical profession would derive its future members.

Sincerely,
Robert E. Field, M.D.

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Oct. 26-28

Nov. 16-18

Contact: Mortimer Enright
Director, AMA Speakers
and Leadership Programs
535 N. Dearborn St.
Chicago, Ill. 60610
(312) 751-6484



Doctor's News

PSRO MEETINGS HELD—ISMS recently held District meetings to obtain from ISMS and IFMC members their ideas on the designation of PSRO areas in Illinois. Invitations to attend these meetings went also to county medical officers, local foundations officers, county executives, ISMS delegates and hospital medical administrators.

The 1973 House of Delegates directed ISMS to “create a unified PSRO plan for Illinois under conditions favorable for physicians. . . .” Based on opinions of the members at the District meetings, ISMS is proposing formation of a non-profit corporation to serve as prime contractor for PSRO, with medical review and other activities delegated to regional and local doctors. Administrative services would be provided by existing and yet-to-be developed foundations for medical care.

Representatives from the Social Security Administration’s Bureau of Health conducted a hearing on PSRO, August 14-15 in Chicago. The hearing was designed only to obtain input from all interested parties on area designation for PSRO. A follow-up second meeting may be held in September.

HMO CENTER OPENS IN WOODLAWN—A community owned and operated comprehensive Health Maintenance Organization (HMO) opened last month in Woodlawn. The center will employ doctors to service patients for a fixed fee paid in advance.

The state provided \$100,000 through the Institute of Social Policy for development of the health center. The center also received \$685,000 from the federal Office of Economic Opportunity and \$45,000 from the U.S. Department of Health.

The Woodlawn Community Development Corp., which owns the Greater Woodlawn Assistance Corp., will operate the health center. Dr. David Fedson is the center’s medical director.

LEADERSHIP CONFERENCE SLATED FOR OCTOBER 21—The annual ISMS Leadership Conference will be held October 21, 1973, at the Drake Hotel in Chicago. A portion of the day’s activities will be devoted to the “how’s and why’s of legislation,” according to Jacob E. Reisch, M.D., chairman of the conference.

In conjunction with the Leadership Conference, Johnson and Higgins administrators of the ISMS Professional Liability Insurance Program, will conduct a conference on Saturday, October 20. The conference is to benefit the district medical review chairmen.

PHYSICIANS IN THE NEWS—New Diplomates of the American Board of Anesthesiology are: Evalinda B. Andaya, M.D., Chicago; Milorad Cupic, M.D., Olympia Fields; Samuel J. DiBona, Jr., M.D., River Forest; Moustafa A. El-Nagggar, M.D., Park Forest; Harold J. Heyman, M.D., Chicago and Hazami F. Khater, M.D., Joliet.

Charles P. McCartney, M.D., Palos Heights, is the new President of the Chicago Medical Society for 1973-74 and **Howard C. Burkhead, M.D.**, Evanston, is the President-Elect.

Lester R. Dragstedt, Ph.D., M.D., formerly of Chicago, was recently awarded the honorary degree of Doctor of Medicine Honoris Causa by the University of Uppsala, Sweden, and has been made a member of the Royal Academy of Arts and Sciences of Uppsala, Sweden.

Alfred J. Faber, M.D., Glenview, is the new President-Elect of the Illinois Academy of Family Physicians. **George B. Callahan, M.D.**, Waukegan, was recently certified as a Diplomate of the American Board of Abdominal Surgery. **Roy Patterson, M.D.**, has been named Chairman of the Department of Medicine at Northwestern Memorial Hospital and Chairman of the Department of Medicine at the Northwestern University Medical School.

Jean D. Lockhart, M.D., F.A.A.P., joined the American Academy of Pediatrics in Evanston as Director of the Department of Committees. **Herbert Notkin, M.D.**, Chicago, has been appointed Director of the Division of Ambulatory Care of the American Hospital Association.

Robert Cohen, M.D., Oak Park, has been appointed to three positions at the University of Illinois Medical Center Campus, Chicago. Dr. Cohen will serve as Associate Professor of Health Care Services in the School of Public Health and as Clinical Associate Professor of Preventive Medicine and Community Health at the Abraham Lincoln School of Medicine. In addition, Dr. Cohen will be the Assistant to the Chief of Staff of the University of Illinois Hospital.

**Drs. Pinsky and Frohman Join
Michael Reese Medical Center**



Dr. Pinsky



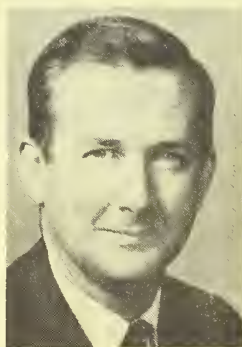
Dr. Frohman

Steven Pinsky, M.D., Deerfield, is the new Director of the Division of Nuclear Medicine, Department of Medicine at Michael Reese Medical Center, Chicago. Dr. Pinsky comes from the Walter Reed Hospital, Washington, D.C., where he was Assistant Chief in the Nuclear Medicine Service Division. He was awarded the Army Commendation Medal for his work at Walter Reed in the development of training programs on nuclear medicine. He also will be Assistant Professor of Medicine and Radiology at the University of Chicago's Pritzker School of Medicine. Dr. Pinsky is a graduate of Loyola University Stritch School of Medicine and he interned at the Evanston Hospital.

Lawrence A. Frohman, M.D., has been appointed Director of Endocrinology and Metabolism, Department of Medicine, at Michael Reese Medical Center. At Michael Reese, Dr. Frohman will be in charge of all endocrinology and diabetes clinics and a newly activated clinical research center. Dr. Frohman will conduct research on control of hormones by the nervous system known as neuroendocrinology. In addition, he will be a Professor of Medicine at the University of Chicago's Pritzker School of Medicine. Dr. Frohman is the Associate Editor of the journal, *Metabolism*.

Beg Your Pardon—In last month's issue the name of Willard C. Scrivner, M.D., was printed in error as William.

**Dr. J. P. Connelly Pediatrics Chairman
At Loyola Stritch's School of Medicine**



John P. Connelly, M.D., Riverside, is the new Chairman and Professor of Pediatrics at Loyola University Stritch School of Medicine. He previously was Associate Professor of Pediatrics at Harvard Medical School, Cambridge, Mass., and Executive Director of Massachusetts General Hospital's Bunker Hill Health Center.

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Any Illinois physician or osteopath licensed to practice medicine in all its branches is eligible to become a participating IFMC member.

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- NORTHERN ILLINOIS FOUNDATION FOR MEDICAL CARE
- QUAD RIVER FOUNDATION FOR MEDICAL CARE

If you haven't already done so **JOIN NOW!**
Sign and return the membership application below to:

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360 North Michigan Avenue - Suite 1418
Chicago, 60601

----- (cut here and return) -----

MEMBERSHIP APPLICATION

In the absence of a local affiliated Foundation for Medical Care, I the undersigned, hereby apply for participating membership in the ILLINOIS FOUNDATION FOR MEDICAL CARE. I certify that I am a licensed physician qualified to practice medicine in all its branches, and eligible for membership in the Illinois State Medical Society.

If accepted as a participating member, I agree to support and adhere to the By-Laws of this Corporation and be bound by the established principles of medical ethics. I agree to cooperate with duly established peer review mechanisms and abide by their recommendations, subject to the right of appeal.

I understand that all programs sponsored by this Corporation will utilize the fee concept current in my local medical community. I reserve the right not to participate in specific Corporation programs if I so notify the Corporation of my intentions in writing.

I recognize that this membership will be automatically renewed annually unless terminated by written notice from either party.

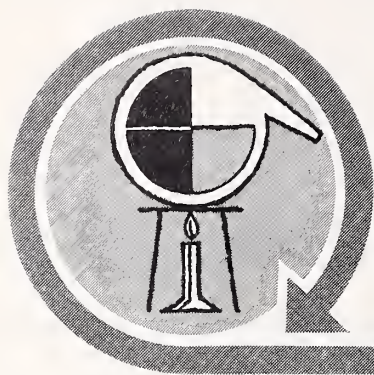
Date: _____ M.D.

(Signature)

(Please Print Name) M.D.

(Street Address)

(City) (State) (Zip Code)



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE DRUGS

ANTAGONATE Antihistamine R

Manufacturer: Dome Laboratories

Nonproprietary Name: Chlorpheniramine maleate

Indications: Allergic reaction of various etiology

Contraindication: Do not use in new born or premature infants

Warning: Do not use while operating machinery

Dosage: Adults: 4 mg. t.i.d. or q.i.d.

Children over 20 lbs: 2 mg. t.i.d. or q.i.d.

Supplied: Tablets: 4 mg.

CELBENIN Antibiotic R

Manufacturer: Beecham-Massengill Pharmaceuticals

Nonproprietary Name: Methicillin Sodium

Indications: Infections caused by penicillinase-producing staphylococci.

Precautions: See Package Insert

Dosage: Intramuscularly or intravenously, for details see Package Insert.

Supplied: Vials: 1, 4 and 6 gm.

CIN-QUIN Tablets Antiarrhythmic R

Manufacturer: Rowell Laboratories, Inc.

Nonproprietary Name: Quinidine Sulfate

Indications: Cardiac arrhythmias; follow the usual precautions.

Dosage: Follow instructions in package insert

Supplied: Tablets: 100 and 200 mg.

FACTORATE Biological R

Manufacturer: Armour Pharmaceutical Company

Nonproprietary Name: Antihemophilic Factor A (Factor VIII, AHF, AHG)

Indications: Classical Hemophilia (Hemophilia A)

Dosage: i.v., adjusted to the needs of the patient

Supplied: Vials, 225 and 275 AHF units

NOVAFED 120 Nasal Decongestant R

Manufacturer: Dow Pharmaceuticals

Nonproprietary Name: Pseudoephedrine HCl

Indications: For symptomatic relief of nasal and otic congestion.

Caution: In severe hypertension, diabetes, hyperthyroidism, urinary retention.

Dosage: Adults and children over 12 years: 1 capsule morning and evening

Supplied: Sustained release capsules: 120 mg.

RHO-Immune Immunoglobulin R

Manufacturer: Lederle Laboratories

Nonproprietary Name: Rh₀ (D) Immune Globulin (Human)

Indications: For use in Rh₀ (D) negative and D(u) negative postpartum women.

Dosage: Refer to package insert

Supplied: Disposable syringe

COMBINATION PRODUCTS

LOESTRIN 1/20 Oral Contraceptive R

Manufacturer: Parke, Davis & Company

Composition: White Tablets:

Norethindrone Acetate 1 mg.

Ethinyl Estradiol 20 mcg.

Brown Tablets:

Ferrous Fumarate 75 mg.

Indications: Conception Control

Contraindications: Past history of thrombophlebitis, thromboembolic disorders, cerebral apoplexy. Marked impaired liver function, carcinoma of breast.

Dosage: White Tablet: 21 days

Brown tablet: 7 days following

Supplied: Each compact contains:

White Tablets 21

Brown Tablets 7

NEW DOSAGE FORMS

CIN-QUIN Capsules Antiarrhythmic R

Manufacturer: Rowell Laboratories, Inc.

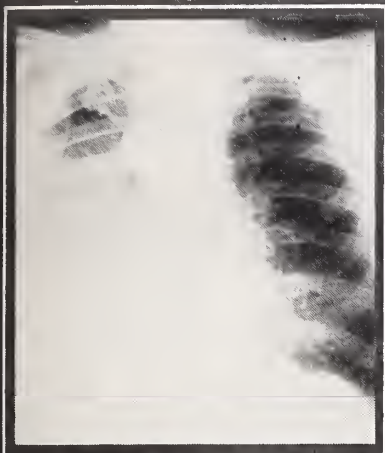
Nonproprietary Name: Quinidine Sulfate

Indications: Cardiac arrhythmias; follow the usual precautions.

Dosage: Following instructions in package insert

Supplied: Capsules: 200 and 300 mg. ◀

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phosphate* 32.4 mg. (gr. ½);
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64.8 mg. (gr. 1). *Warning—
may be habit-forming. Each
tablet also contains: aspirin
gr. 3½, phenacetin gr. 2½,
caffeine gr. ½.

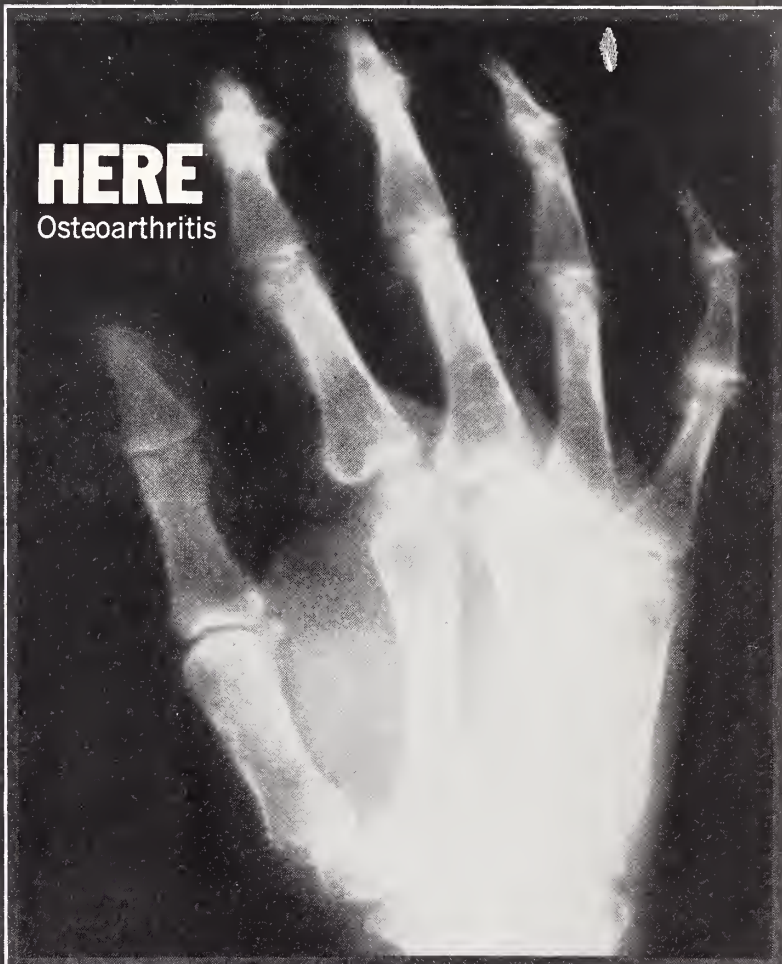


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Editorials



License Renewal

All physicians and surgeons practicing in the State of Illinois have to renew their license every two years. The Department of Registration and Education charges \$10.00, but adds a \$5.00 penalty when the application is late. The Department does not send a notice telling the physician that renewal is necessary. As a result, it is easily forgotten and there must be many practicing physicians, including those in semi- or full-retirement, who think they are licensed, but are not.

We wonder what is done with the \$10.00 fee that more than 12,000 physicians pay into the Department of Registration and Education every two years. Many must also pay the 50% penalty. We suspect that the \$10.00 is just another tax, but if it is used to pay for the work entailed in licensing, it is only fair that this department spend 10 cents of it to send us a mimeographed postcard warning us that renewal is due.

T. R. Van Dellen, M.D.
Editor

Mini-Editorial

Before it is too late, convince your patients that the government is not the answer to all their problems. Remind them also that bureaucratic Washington cannot and never has been able to do anything at less cost than private enterprise. This does not mean that many elected officials are not capable and intelligent. There are just too many mediocre people who have their fingers in the pie. It is the nature of government. So long as these bodies can tax and tax, there is nothing to keep them from getting bigger. Unfortunately, in this case, bigger is not better. And, the bigger they are, the less economical and efficient they become.

T. R. Van Dellen, M.D.
Editor



report

Illinois Society
American Association of Medical Assistants

AAMA-ILL. SOCIETY

ANNUAL SYMPOSIUM
Sunday—September 16, 1973
Holiday Inn, 1040 Dixie Highway
Chicago Heights

“KEY TO SUCCESS”

PROGRAM

Registration with Coffee and Rolls, 8:30-9:30

Pledge of Allegiance—Ethel Haase

Welcome—Roman Filipowicz, M.D.

Pres. Elect, South Cook County Med. Society

Greetings—Norma Domanic
Virginia Daley

Introductions: J. Berschinski

“Key to Your Rights & Responsibilities”

Panel Discussion

Physicians: Philip Thomsen, M.D.

Maurice Hoeltgen, M.D.

Attorneys: William North

James Fletcher

Insurance Rep.: Larry Kosnitt

Hospital Adm.: Robert Harris

LUNCHEON

Luncheon Speaker:

Mrs. Elmer Geissler

AFTERNOON SESSION

“The Hang-Up Key”

John Lowney, M.D.

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Rt. 1, 1040 Dixie Hwy., Ph. 312-756-0300

REGISTRATION DEADLINE SEPTEMBER 10, 1973

The Cooper Quiz

This self-assessment test is part of the "Cooper Quiz," a monthly publication of the Department of Medical Education, Cooper Hospital, Camden, N.J. 08103.

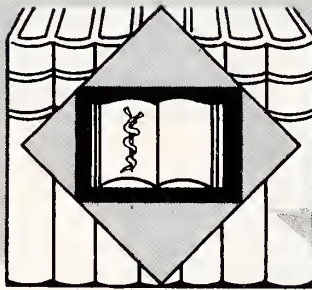
True or False

1. Cholesterol is the parent substance of the steroid hormones.
2. The fetal adrenal may be involved in the timing of the gestation period.
3. Aldosterone and other mineralocorticoids do have a direct and acute effect on blood pressure.
4. The kidney is the major organ responsible for metabolic conversion of steroid hormones.
5. Glucocorticoids cause muscle hypertrophy.

ANSWERS

1. **True** "Cholesterol is the parent substance for a number of important chemicals including the bile acids and the steroid hormones. During development it is found in large amounts in the fetal liver, in the placenta and in the fetal adrenal." *Am. Jour. Med.* (November 1972, pg. 535).
2. **True** "Just as placental hormones may influence the development of the fetal adrenal and testis, there is now increasing evidence that the fetal adrenal may be involved somehow in the timing of the gestation period. The length of gestation in man is related to the level of uterine contractility. This, in turn, can be related to the size of the fetal adrenal. Unexplained premature labor may be associated with hyperplasia of the fetal adrenal whereas prolongation of pregnancy may be related to hypoplasia of the adrenal." *Am. Jour. Med.* (Nov., 1972, pg. 541).
3. **False** "Aldosterone and other mineralocorticoids do not have a direct or acute effect on blood pressure. Only after prolonged administration of a mineralocorticoid does hypertension ensue which is secondary to alterations in sodium metabolism. Exchangeable sodium and extracellular fluid volume are increased. Reduced sodium intake will prevent the development of hypertension associated with mineralocorticoid administration." *Am. Jour. Med.* (Nov., 1972, pg. 568).
4. **False** "The half-times of disappearance of glucocorticoids from plasma are in part determined by the rate of their metabolism. In general, liver is the major organ responsible for metabolic conversion of steroid hormones, although enzymes that metabolize steroids are found in most tissues." *Am. Jour. Med.* (November 1972, pg. 576-577).
5. **False** "The generally catabolic actions of glucocorticoids on this tissue result in the muscle wasting and myopathy which are well established characteristics of Cushing's syndrome. Although a direct effect of this tissue on total glucose uptake by glucocorticoids has not been demonstrated, the uptake of glucose relative to the existing hyperinsulinism and hyperglycemia appears decreased." *Am. Jour. Med.* (November 1972, pg. 583).

the doctor's library



PEDIATRIC CARDIOLOGY. By Alexander S. Nadas, M.D., F.A.A.P. and Donald C. Fyler, M.D., F.A.A.P. Third edition. (W. B. Saunders Co., 1972.)

It is a pleasure to read the third edition of Drs. Nadas and Fyler's text, *Pediatric Cardiology*. A comprehensive discussion of the basic concepts of pediatric cardiology is presented including historical information, diagnostic tools, clinical data, differential diagnosis, medical and surgical management, and, prognostic implications. In discussing hemodynamics, the authors do not presuppose a prior knowledge of fundamental principles. Yet, the reader is not hindered by intricate details relative to various technical procedures. This text is, therefore, of value to both the pediatric cardiologist and the pediatrician.

In comparing this new edition with the previous, several features are worth noting. A thorough review of the literature and an excellent up-dated bibliography are presented. Valuable statistical tables and classification indices obtained from various study groups and authors are printed in the appendix. Illustrations are of the same quality and clarity and more numerous. Current concepts relative to indications for cardiac catheterization, operative procedures and risks involved are discussed in a logical fashion. The trend in modern pediatric cardiology towards earlier and more comprehensive care of the infant affected with CHD is expressed. As before Dr. Nadas' humorous commentaries are appreciated.

We are indebted to Dr. Nadas and Dr. Fyler for enhancing our knowledge in this ever expanding area of medicine.

Julie A. Luken, M.D.

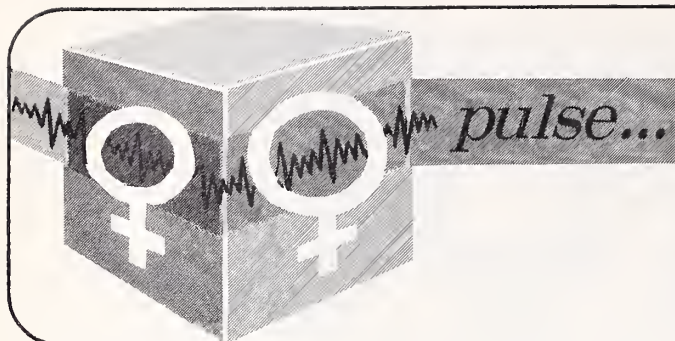
DAVIS-CHRISTOPHER TEXTBOOK OF SURGERY. Edited by David C. Sabiston, Jr. (W. B. Saunders Company, Philadelphia, 1972.)

Doctor David Sabiston has achieved the goal set in his Preface in an admirable fashion. He stated that emphasis would be placed on biological principles in the treatment of surgical problems; and indeed, the fundamental features, diagnosis, and treatment have received appropriate presentation in this text.

Doctor Sabiston made an excellent choice of authors, for the chapters, who are well known in most instances for the topics that they present. The organization of the book follows the general pattern of previous editions, and the illustrations are of excellent quality, appropriate, and carefully selected. A particularly appealing addition has been the use of annotated references which provide the reader with a concise summary of the contents. A number of new chapters have been added which include one by Dr. John Siegel, "Computers and Mathematical Techniques in Surgery"; Dr. Robert H. Jones' section, "Radioisotope Techniques for Diagnosis of Surgical Disorders"; and a chapter by Doctors Donald Morton and Samuel Wells, "Immunology of Neoplastic Disease."

The material is presented in a comprehensive and lucid manner; despite the use of multiple authors, there is a remarkable evenness of presentation. The comprehensive nature of the book, the updating of previous chapters, and the inclusion of new material makes this an outstanding source of reference for medical students and surgical residents. ◀

John M. Beal, M.D.



pulse... of the doctor's wife

MRS. ROSANNE K. FRANK, *Editor*

Choosing to Care

Dear Doctor's Wife,

You have the power to choose to care. What you do with 'your time and energy' is determined by the choices you make. To make the right choices you have to ask yourself four questions—Is it true?, Is it Good?, Is it effective?, and Is it Lasting? And a most important fact remains the same—your choices help determine the quality of your life and the lives you touch. To be at peace within yourself it is wise to remember that a moment of glory or the capture of a prize can bring little comfort if the four questions cannot be answered with a "Yes."

Happiness and a sense of well-being is more easily found in the daily acceptance of the challenges, struggles and benefits that life brings to each of us so that through them we can continue to grow, mature and accept ourselves as part of the world of order that is good.

To experience the good life, you must be a part of it! As a doctor's wife you have opportunities and privileges in abundance to show your concern for people found in a wide range of varying conditions. When you married an M.D. you also chose to be identified with the world of medicine; through this identity you can contribute effectively to the enhancement of the state of well-being for all people. The auxiliary, which you may choose to be a part of, is medicine's mechanism through which you can help—it provides membership in an organization concerned with health (where you can share your interest with your husband); it pro-

vides programs which are the tools of operation and it provides the pathways necessary to communicate with others the ever-present similar interests, desires, and problems.

Along with the county, state and national organizational structures there is the opportunity to share our mutual concerns on a regional basis. We of the 12 states of the North Central Region can pool our thoughts, compassion, resources, efforts and all the other aspects of our common existence to help bring a good life to all. For you the unavoidable by-products happiness and self-fulfillment will be yours, made possible by your giving them to others.

In Illinois you can proceed with the right choices and avoid the wrong if you contact those who can assist you in charting your course. There are those who can make it possible for you to be a member, work through programs and communicate to make 'it' happen! You have the power to choose. How will you chart your journey and What are your priorities for the quality of it?



Eunice Roller, *Vice President*
North Central Region, WA-AMA

Mrs. Glatter Elected to a New Position

Mrs. Thomas ("Mickey") Glatter, Rockford, was elected as "Acting" President-Elect at the WA/ISMS Board meeting, July 9. In addition to this new position, Mrs. Glatter will maintain her duties as Vice-President in charge of membership for the remaining nine months of office.

The position of president-elect became vacant upon the resignation of Mrs. Franklin Yoder, Springfield, Dr. and Mrs. Yoder are moving to Greeley, Colo., where Dr. Yoder has been appointed Director of the Weld County Health Department.



Mrs. Thomas Glatter

Mrs. Glatter participates in auxiliary work at St. Anthony's Hospital in Rockford, where she has served as a volunteer Public Relations Director. She has held various board positions for the Winnebago County Medical Auxiliary.

Since 1968, Mrs. Glatter has served as WA/ISMS Health Careers Chairman. In 1972, she was the chairman for the WA/ISMS annual meeting.

She and her husband, an internist, have two daughters, Susan and Kathryn.

From the Editor's Desk . . .

With your help, we can make these pages of PULSE a meaningful way of keeping in touch with activities and plans throughout the state. Please send me any news items or pictures you have that pertain to auxiliary activities.

Mrs. Irving Frank, *Editor*
135 S. Sacramento
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They laughed when I bought my first Bond.

In my neighborhood everyone was poor. Most of us were lucky if we had enough food to eat or clothes to wear. So like most kids we spent a lot of time talking about the things we wanted out of life. Things like owning a big car, wearing fine clothes and going to all of the best places. Boy, we could hardly wait to grow up.

Like the other kids I had little odd jobs in grammar school but I got my first real job when I started high school. I was a junior clerk in a big department store. That's where I first heard about U.S. Savings Bonds. My boss asked me if I wanted to join the Payroll Savings Plan and I said yes. A month later I got my first bond.

When my friends found out they really had a good laugh. Imagine buying U.S. Savings Bonds when there were so many other great things to buy. Well, they kept laughing and I kept saving all through high school.

After graduation some of us wanted to go to college. And that's when my Bonds really

came in handy. They not only helped pay my tuition, but also helped buy some books.

Well, I'm a senior now and looking forward to graduation. Unfortunately, a lot of my friends never even got started. And to think, they laughed when I bought my first Bond.



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Take stock in America. Buy U.S. Savings Bonds.

Score Yourself on VD Quiz

(Continued from page 141)

Key for grading your performance on the venereal disease quiz: Correct answers: 1, D; 2, B; 3, C; 4, C; 5, C; 6, A; 7, C; 8, C; 9, A; 10, B; 11, A; 12, B; 13, A; 14, A; 15, B; 16, A; 17, B; 18, B; 19, A; 20, B; 21, A; 22, C; 23, E; 24, B; 25, D; 26, B; 27, D; 28, B, and 29, D.

SCORING

Percentage of Correct Answers	Number of Correct Answers (29 Questions)
90-100	27-29
80-89	24-26
70-79	21-23
60-69	18-20
50-59	15-17
40-49	12-14
30-39	9-11
20-29	8 or less

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 13 manuscript pages**, including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for

the accuracy of references used with articles.

The first page should list the title, the name of the author (s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. On the back of each illustration indicate number, the top, and author's name.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
Illinois Medical Journal
360 N. Michigan Ave.
Chicago, Ill. 60601.

The Way to A Man's Heart Attack

(Continued from page 127)

4. A low-fat diet must perforce be relatively higher in something else—carbohydrate probably. This may be undesirable for diabetics, it may lead to high triglyceride blood levels in some people, and will lead to high levels of circulating insulin in everyone else. A new theory of atherosclerosis is based upon a relationship between increased levels of insulin and atheroma formation.³²
5. A low-fat diet supplement by polyunsaturated oils seems ideal from the point of view of the blood cholesterol, but no large population group has ever subsisted on such a diet for very long. Who knows what new disease—cancer has been suggested by the Los Angeles V.A. study³³—may be enhanced by this diet to compensate for the cardiovascular benefits we might gain from subsisting on such a diet?

As in every environmental problem: when one tampers with the ecology, it is not always possible to predict the final outcome. It is for this reason that most investigators interested in this problem feel that it is important that a mass field trial be undertaken on a fair cross-section of our healthy population.³⁴ If the recommended diet can be shown to reduce the incidence of first heart attacks with no unexpected ill effects, we can then confidently recommend that diet for the nation, reorganize our laws and tax structure to encourage the desirable diet and discourage or modify the undesirable meat fat, eggs and dairy products. ◀

References

A complete bibliography for "The Way to a Man's Heart Attack" may be obtained from the *Illinois Medical Journal* office, 360 N. Michigan Ave., Chicago, 60601.

Drug Treatment of Hyperactivity in Children

(Continued from page 119)

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Health Providers

While most health providers still enjoy a high degree of respect and appreciation from patients and the general public, the "God-like" image of health providers, particularly doctors, is fast being accepted for what it is—ERRONEOUS. Consumers, all over the country, view doctors in a proper mortal prospective. As mortals, they are capable of errors and other human shortcomings. However, increased numbers of Americans know that many of the improper procedures which lead to medical injury or damage need not exist.

Doubts and undue prolonged pain after medical treatment have caused patients to delve into their cases more thoroughly. Gathering needed information frequently has been unduly costly to the patient or his guardian in terms of money, anxiety, and body fatigue. Nevertheless, the patient only seeks the truth to attest to the quality of health care he has received.

The majority of the consumers recognize many of the good facets in our present health care system. At the same time, these consumers recognize the many deficiencies in our present health care system which result in pain, suffering, and sometimes death. Many of these deficiencies need not exist. Large numbers of consumers are requesting changes which will eliminate or decrease the deficiencies and medical malpractices. At the same time, they are requesting improved quality care and accessibility of health care goods and services for all Americans. (Separate Statement of Ella L. Strother: "Separate and dissenting statements." *Medical Malpractice* (Jan) 1973, pg. 134).

EKG of the Month

(Continued from page 135)

Answers: 1. e 2. c

The ST elevation seen in tracing is suggestive of early repolarization. Serial electrocardiograms showed no change. This condition is benign but may be confused with more common causes of ST segment elevation—current of injury of acute infarction or acute pericarditis. The clinical picture and serial electrocardiograms can establish the correct diagnosis. The chest pain in this patient was in origin and responded well to aspirin and diazepam. ◀

Pediatric Perplexities

(Continued from page 136)

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AMA PUBLISHES NEW EDITION OF PROCEDURAL TERMINOLOGY BOOK

More than 2,000 new and revised medical procedures are listed in the Third Edition of the American Medical Association's *Current Procedural Terminology*.

CPT is a listing of medical terms and identifying codes for reporting medical services and procedures performed by physicians. The book provides a uniform language to designate accurately medical, surgical and diagnostic services, thereby providing an effective means for reliable, nationwide communication among the providers of medical care, the patient and third party payers and carriers.

In recent years, the reporting requirements by third parties and the emphasis on the delivery, utilization and evaluation of medical care have been matters of concern to physicians. These factors have caused a greatly increased volume of paper work for physicians and have stressed the need for accurate reporting of services rendered.

CPT was created by the AMA to provide for physicians a means to identify services in a uniform manner and to facilitate record keeping both by the physician and by the third party payer, such as Medicaid, Blue Shield or private insurance.

The common language may also be related to medical research and education and may provide a useful basis for which variations for local and regional utilization as well as national application and comparability can be developed.

The Third Edition of *CPT* has been prepared and studied by physicians, aided by consultants, from the various medical specialties. The text can be used in the development of billing systems, for administrative management purposes and in the development of guidelines for medical care review.

In applying the common language of *CPT* for use in computers, a five-digit code is utilized. The use of *CPT* code simplifies the reporting of services. The physician using *CPT* terminology with coding selects that procedure which most accurately describes the service performed. This is the basic service. In surgery, it may be an operation; in medicine, an office visit; in X-ray, a chest radiograph. Other procedures performed in addition to the basic service also may be listed.

The main body of the material is listed in five sections: Medicine, Surgery, Radiology (including Nuclear Medicine and Diagnostic Ultrasound), Pathology, and Laboratory, and Anesthesiology.

A complete alphabetical index is in the back of the book. Specific guidelines for using the book and its codes are presented at the beginning of each of the five sections.

A Statewide System For Post Traumatic Renal Failure

(Continued from page 138)

sonnel in the care of acute renal failure patients during transportation.

Conclusion

The statewide network for treatment of acute renal failure will result in optimal care of the severely ill, hypercatabolic and frequently infected patient with post-traumatic renal failure in renal centers with modern facilities and trained personnel. With early, "prophylactic" dialysis, intravenous alimentation⁵ and careful management of complications, it is hoped that the overall prognosis of post-traumatic renal failure will be improved and that patients who now die may be saved. ◀

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Physicians Asked to Refer Malignant Melanoma Cases

Physicians have been asked to cooperate with the National Cancer Institute by referring patients with malignant melanoma for studies by NCI's Immunology, Surgery, and Medicine Branches at the Clinical Center, Bethesda, Md.

The project is designed to evaluate the effects of chemotherapy and immunotherapy in stage 3 disease (clinical evidence for systemic metastasis) and stage 2 disease (clinical evidence for regional draining lymph node metastasis).

Physicians interested in having their patients considered for admission to these studies should communicate with Dr. Richard I. Fisher or Dr. William D. Terry at the National Cancer Institute; Building 10, Room 4B17; Bethesda, Md. 20014. The telephone numbers are (301) 496-2455 and 496-5461. (*Medical Tribune*)

MD Must Make the Decisions On Treatment, Not a Computer

A physician should be able to base his treatment on what he thinks is best for the patient rather than on the recommendations of a computer, William J. Guste, attorney general of Louisiana, said at the meeting of the Council of Medical Staffs.

Doctors are now facing encroachment by the government and private businesses, both of whom rely on computers to establish norms of quality health care, he said.

In good part, this is the fault of the physicians who "were so busy treating the sick that they ignored the need for planning for and working towards a national goal of adequate medical care for all Americans."

Through organizations like the Council, there is a new voice to bring the opinions of the private practicing physician to the planners and bureaucrats who will set up future programs, he said.

"I believe, as I am sure you do, that there is nothing that can cause the deterioration of quality medical care more than the politicalization of medicine under federal control," said Mr. Guste, former counsel to the Council.

The government should set its sights on providing medical care for those who need it and cannot afford it—not for those who can pay. Blanket prepaid health care programs will glut the doctors' offices with the "worried well," who will strain the system and deny the physicians' time and care to those who really need them.

The Council should support a medical insurance program for the 21 million Americans who are below the poverty level. This will guarantee that care is available to those who need it, without the drawbacks of socialized medicine. It will save the taxpayer's money while allowing him to visit the doctor of his choice, Mr. Guste said.

"The national goal should be to provide for the underprivileged, for those who cannot afford it themselves, a uniform basic medical coverage policy through private insurance companies," he said.

National health goals should be fixed on three points: the patient must have access to the doctor; the doctor must be competent; and the doctor must make the decision on what is best for the patient. (*Internal Medicine*)

Comment From PMA*

A portion of the day will be devoted to the “how’s and why’s” of legislation.

Watch for more details in the September issue of the *IMJ*

We have made no criticisms of FDA personnel for failure to move expeditiously in considering particular NDAs. Our criticism is of a system whose net effect seems to be to inhibit the introduction of significant drugs to the largest medical care system in the world and efforts by some to conceal the fact.

Our comments on the long delays that have been encountered in the availability of significant new drugs in this country should be of serious concern not only to medicine and the pharmaceutical industry, but to consumers and the FDA as well. Although some progress has been made in recent years toward speeding up the NDA process, nevertheless, questions must be raised when it takes years longer to prepare and process NDA information for the FDA than for its sister agencies in well-developed nations overseas. Our regulatory procedures make such voluminous demands for data that it is frequently impossible to meet them within a reasonable length of time. Often, those demands amount more to a barrier to progress than a contribution to consumer in-

terests. Indeed, the typical NDA has grown so enormously in size that its bulk alone is a cause of delay once the application is presented to the FDA for evaluation.

Questions need to be raised as to why it is possible to prepare, submit and gain marketing approval for certain compounds in sophisticated foreign nations, in less time than is required simply to gather the quantity of information required to submit an NDA in this country.

At the end of all regulatory and administrative processes through which a new drug must pass in any country stand patients in need of medication. It seems to us that the American regulatory maze has all but obscured that fact, and that defenders of the status quo have too long excused this system, ignored potential benefits lost and overstated the “safety” achieved by failing to permit new drugs to reach the market expeditiously.

*The Pharmaceutical Manufacturers Association released the following comment on the FDA's response to PMA criticisms of the February 5, 1973, testimony of Dr. Henry Simmons before the Senate Small Business Subcommittee on Monopoly.

Plan to Attend the **ISMS LEADERSHIP CONFERENCE**

Sunday, October 21, 1973

Drake Hotel – Chicago

Jacob E. Reisch, M.D., Chairman

Purchase of Medical Practice on Percentage Basis

The purchase of a medical practice on a percentage basis is contrary to and in violation of the Principles. A physician may pay anything he wants to for the practice as long as a set price is established, but it is unethical for a physician to pay a percentage of the income of the practice that he has purchased as payment for it. The use of a percentage of fees or an indefinite sum as the purchase price for a medical practice results in dividing fees paid for professional services with a third party—a stranger to the physician-patient relationship. Once a price has been established it may be paid according to the mutual agreement of the parties. Payment of such an established price predicated on a percentage of the income of the purchaser is not contrary to the Principles. It is axiomatic that a physician must bill a patient for professional services that he renders to the patient. He must not divide that fee with another. Such practice violates the physician-patient relationship and may be regarded as a commission for having referred the patient. Further, the use of a percentage arrangement indirectly tends towards solicitation of patients for or on behalf of the purchasing physician, because the seller clearly derives greater profit from greater income.—*Opinions And Reports, Judicial Council for the AMA.*

★

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16th Annual Fall Conference on Nutrition in Medicine

Eugene F. Diamond, M.D.
Program Chairman

October 5, 1973

Sheraton Motor Hotel

Rock Island, Ill.

PROGRAM

- 10:30 a.m. — Opening/Introductions
- 10:45 a.m. — “Drug Induced Vitamin Deficiencies”
Daphne A. Roe, M.D., Associate Professor
Graduate School of Nutrition
Cornell University, Ithaca, New York
- 11:30 a.m. — Lunch
- 12:30 p.m. — Panel “Nutrition and the Athlete”
- 2:00 p.m. — “Meat and Meat Extenders”
William C. Sherman, Ph.D.
Director of Nutrition Research
National Live Stock and Meat Board, Chicago
- 2:45 p.m. — Coffee Break
- 3:00 p.m. — Panel “Nutritional Lifestyle and the Heart”
- 4:30 p.m. — Adjournment

Sponsored by:
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Moline Lutheran Hospital
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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (10)

ALEDO: Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Forth Street, Aledo, 61231, 309-582-5156. (9)

CHICAGO: Field Clinic has opening for an Internist with a specialty either in allergies, rheumatology, or gastroenterology. Salary is open. The Field Clinic is one block from Ravenswood Hospital, which is a 400 bed medical center. Contact: Kenneth Hatfield, M.D., 4600 N. Ravenswood Ave., Chicago 60640. 312-275-7700. (8)

CHICAGO: Local Medical Examiner, half or fulltime, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, G.P., or surgeon. Salary negotiable, excellent benefits. Call 431-4671 or write Room 708, 122 South Michigan, Chicago, 60603 for information. (9)

CHICAGO: Opening in welfare clinic, south side; no hospital work. Guaranteed salary. Good opportunity to work into a part-ownership. Contact: Robert C. Parro, Chicago Medical Center, Inc., 657 W. 79th St., Chicago, 60620, 312-994-0100. (11)

CHICAGO: The Cancer Prevention Center, a multi-phasic health screening facility, seeks internists, surgeons, gynecologists for its comprehensive health examinations. Employment is part time. Interested physicians are invited to visit and apply. Please contact the office of Angelo P. Creticos, M.D., 33 W. Huron, Chicago, 60610, 312-944-4371. (11)

CLINTON: General Practitioners needed for rural community. Population 8,000. 50 bed JCAH hospital. Located 25 miles from Bloomington and Decatur and 40 miles from Springfield. This community offers good schools and educational opportunities, recreational areas, and shopping areas within a short distance. Medical Staff needs your help. Contact: Dr. Charles Ramey, 215 East Main Street, Clinton, 61727, 217-935-2191. (12)

DANVILLE: Population 45,000; Drawing area more than 100,000. Primary need in General Practice-Family Physician, however many specialties also required. Excellent hospital facilities; many specialties well represented. Fine community, affiliation with the University of Illinois Medical School available. Office space available. Contact: W. N. McCormack, M.D., 812 N. Logan Avenue, Danville, 61832, 217-443-5362. (11)

DU QUOIN: Population 7,000, 75 miles South of St. Louis and 20 miles north of Southern Illinois University. 1 Surgeon and 1 General Practitioner & OB GYN. Excellent opportunity for both to build lucrative practice. Brand new hospital with all new equipment and facilities. Present hospital board and staff will support. Office spaces can be made available. Area has good recreational facilities, good school and shopping areas. Contact W. M. Thornburg, M. D., 111 W. Main St., Du Quoin 62832 618-542-2137. (9)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (9)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D. 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (9)

FREEPORT—Population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multi-specialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include \$50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALENA: Pop. 4,000. Family/General Practitioner needed to join three other FPs. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 80,000. Historical community offers very good school systems, numerous churches, and outstanding recreational facilities. Contact: Wilbur E. Johnson, M.D., 300 Summit Street, Galena, 61036, 815-777-0900. (11)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (9)

GENERAL MEDICAL SERVICES, LTD ("Physicians-On-Call"): Emergency room, house call, clinic work available in 16 hospitals and clinics throughout State: Chicago, Peoria, Dixon, Bloomington, etc. Full-time or part-time work available. Contact G. M. Gnertner, M.D., 153 West Lake Street, Bloomingdale, 60108, 312-627-3404. (12)

HARRISBURG: 4 General Practitioners, Cardiologist, OB-GYN and Ophthalmologist wanted. Population of 10,000. Modern hospital to practice in. Please contact Carl L. England, Jr., Administrator, Doctors Hospital, Harrisburg, 618-253-7671. (11)

HARVARD: Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing area and financially sound. Sixty five miles northwest of Chicago, thirty miles east of Rockford. Community committee, including present doctors. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033. 815-943-5261. (9)

HERRIN: Int., G.P., ENT, Anesth. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (11)

LAKE FOREST: Internists, certified or eligible, needed to practice in fine north shore community, with excellent earning potential. University appointment desirable. Excellent hospital with all specialist medical staff. Contact: Steven L. Seiler, Lake Forest Hospital, Lake Forest, 60045, 312-234-5600. (9)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D.,

Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (9)

MACON: Thriving community of 1600. Five of seven nearby towns without resident physician. Adequate unfurnished building available. Assistance given to become established. Located 8 miles south of Decatur (two first-class hospitals). Excellent schools. Five churches. Contact: Olive Johns, 250 W. Ruby St., Macon, 62544, 217-764-3483. (11)

MINONK: Population 2,500. Serving a patient area of over 10,000. Opening in new Medical Clinic, Inc. Twenty-five miles from two Universities in Bloomington and in Peoria. Schools, churches and facilities nearby. Contact: H. T. Barrett, M.D., 200 E. Sixth St., Minonk, 61760, 309-432-2525. (10)

MONMOUTH: Services area population 30,000. Opening for General Practice and OB-GYN. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (9)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (9)

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265. (11)

OTTAWA: Population 20,000. 75 minutes from Chicago loop via Interstates. Completely equipped ground floor physicians office with adjacent parking space. Enjoy good living and recreation as well as congenial professional relationships. Entirely new 125 bed hospital due to open this October. No traffic, no smog, just excellent family living. Contact: E. R. Maierhofer, M.D., 226 W. Madison St., Ottawa, 61350, 815-434-7418. (12)

PANA: We need 2 physicians to practice general medicine in a friendly active community of 6,500. 45 minutes from Springfield or Decatur, 1½ hours from St. Louis. Economy is farming and light industry. 5 schools, 16 churches, parks, clubs, lakes, etc. Contact John Luff, Pana Hospital, Pana, 62557, 217-562-2131. (9)

PLYMOUTH: Population 800 plus large rural drawing area. Ten-year-old clinic & office building (large) available. Two closest hospitals 18 miles. Large Illinois University 18 miles. Golf course, hunting, fishing, etc. close by. Grade and high school in town. Contact: Ken Smith, Box 21, Plymouth, 62367, 309-458-6241. (9)

PONTIAC: Population 11,000, trade area 50,000. 100 miles south of Chicago on Route 66. Wanted: family practitioners. Office space available adjacent to hospital. Contact: Dale Budde, St. James Hospital, 610 East Water St., Pontiac, 61764 or call collect: 815-844-5134. (9)

RIDGE FARM: Population 1,015. Seventeen miles south of Danville. No physician at present. Complete office facilities. Financial assistance available if needed. Contact: Nolin Weathers, 207 E. North St., Ridge Farm 61870. 217-247-2265. (8)

ROSICLARE: G.P., Ped. Hospital serves 2 counties—approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (9)

STREATOR: Physician to join three other G.P.'s in general practice group. All privileges available in beautiful new hospital to qualified M.D. Modern clinic building, well staffed. Generous salary to start, full partnership available after trial period. Rotating office hours, night and week-ends off, vacation, etc. Contact: George Powers Jr., M.D. and James E. Gottemoller, M.D., 301 S. Bloomington Street, Streator, 61364, 815-672-2133. (10)

STREATOR: Family Physician needed to join 10 man (2 family physicians) multispecialty group in community of 20,000, with new clinic building across from hospital, excellent practicing facilities for energetic physician, full insurance benefits, guaranteed income; teaching opportunities. Contact: C. T. Hawkins, M.D., Streator Medical Clinic, S.C., 104 Sixth St., Streator, 61364, 815-672-0511. (12)

WASHINGTON: Population 10,000 plus, need family physician; financial assistance available, office of doctor, recently retiring, with some equipment available. Ten minutes from Peoria. All recreational facilities available in or near Washington. 1 year free use of car provided, 6 mo. rent free residence available. Con-

tact: Dean R. Essig, 139 Washington Square, Washington, 61571. (7)

WENONA: General Practice Opening. Population 1,200. Several nearby communities without physicians. Only physician wanting to retire soon because of health. 15 miles from new St. Mary's Hospital at Streator. Office space and financial assistance available. Excellent schools. Contact: William Gilman, M.D., 407 1st North St., Wenona, 61377, 815-853-4511. (10)

WEST FRANKFORT: GP to take over well established practice in scenic Southern Illinois. Enjoy serenity of small town living, population 9,000, in center of rapidly expanding recreational facilities. Hospital in town. No investment needed. Call or write: C. E. Ahlm, M.D., 107 S. Van Buren, West Frankfort, 62896, 618-932-5015. (10)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Population 15,000. Two man corporation desires Generalist or Internist. Complete office facilities. 130-bed general hospital. Approximately 60 miles from Chicago. Salary open depending on qualification and experience, with partnership in 2 years if agreeable. Contact Dr. H. A. Stahlecker, Jr., & Dr. P. D. Exconde, 666 W. Jackson Street, Woodstock 60098, 815-338-2210 Collect. (9)

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9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Obituaries

***Black, C. Ellsworth**, Jacksonville, died June 5, at the age of 80. He had practiced in Jacksonville from 1918 to 1968 and was a member of the Illinois College Board of Trustees from 1946 to 1971. Dr. Black was a 1920 graduate of Washington University.

***Brown, Charles E.**, Penfield, died May 27, at the age of 63. He had been a practicing physician in the Penfield community since 1935. He graduated from the University of Illinois College of Medicine in 1935.

***Burhans, Donald L.**, Peoria, died June 1973. He was a 1944 graduate of the University of Cincinnati.

***Dolaz, Edward**, DeKalb, died June 14, at the age of 55. He received his medical degree at Loyola University Stritch School of Medicine. He was a Fellow Hematologist and a certified member of the American Board of Internal Medicine. Dr. Dolaz was an associate attending physician at Cook County Hospital and consulting staff member and attending physician at DeKalb Public Hospital. He has also been a consulting staff member of Sycamore Municipal Hospital and a clinical instructor at Loyola University Stritch School of Medicine since 1951.

***Hurn, Hal T.**, Chicago, died June 7, at the age of 49. He was a member of the faculty of the Chicago Institute of Psychoanalysis and secretary of the Chicago Psychoanalytic Society.

Hussey, B. E., Chicago, died July 1, at the age of 81. He was a member of the staff of St. Anne's Hospital for over 40 years.

Kelly, Thomas J., Wood River, died April 22. He was a graduate of Beaumont Medical School in St. Louis.

***Lamb, Patrick F.**, Belleville, died May 27, at the age of 49. He was a physician and surgeon for diseases of the chest.

****Levin, A. Louis**, Chicago, died June 19. He graduated from the University of Illinois College of Medicine in 1922.

***Muehloff, Dimo**, Chicago, died May 30. He graduated from Medizinische Fakultät der Ludwig Maximilians-Universität, München, Bayern, Germany in 1912.

****Parmenter, George H.**, Beecher City, died June 9. He received his medical degree from the National University of Arts and Sciences in St. Louis.

***Prestipino, Frank E.**, Blue Island, died June 26, at the age of 49.

***Raider, Jack H.**, Chicago, died June 27. He was a 1933 graduate of Loyola University Stritch School of Medicine.

***Roseborough, Albert S.**, Rockford, died at the age of 73. He was a graduate of McGill University Medical School in Montreal. In 1937 he organized the first Rockford police officers' first aid program and was one of the founders of the Woman's Ambulance Safety Patrol (WASP) in 1940. The WASP served in emergencies, particularly through cooperation with Camp Grant.

****Rosenstern, Iwan**, Evanston, died at the age of 91. He had been on the staffs of Evanston, Childrens Memorial and St. Francis Hospitals. He received his medical degree from the Rush Medical College in 1906.

***Shymaniv, Wasyl**, Chicago, died January 12.

***Wadsworth, Harold**, Joliet, died June 16. He graduated from the University of Illinois College of Medicine in 1928. ◀

*Denotes member of ISMS
**Denotes member of 50-year Club and ISMS

The Following Letter Has Been Sent School Superintendents in Illinois . . .

On December 14, 1971, the Governor of Illinois signed an Amendment to Section 27-8 of the *School Code*. The essential element of the Amendment consists of the following paragraph:

"A sickle cell anemia test shall be administered to each pupil by request of the examining physician when he determines such test necessary. The physician shall state on the examination form whether such test was given. The results shall be reported on the form. All positive results of the sickle cell testing shall be filed with the examining physician and the Department of Public Health."

In order to comply with the reporting requirement, the Maternal and Child Health Section of

the Illinois Department of Public Health suggests adding the following lines to the back page of the School Health Examination Record.

Result of sickle exam if given:

Abnormal Hgb Type: ____SS____AS____

Other _____

Normal Adult Type of Hgb: _____

Richard A. Haney
Associate Superintendent
Division of Pupil and Professional Services

Bill D. Page
Assistant Superintendent
Department of Pupil Services

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone: (217) 337-3239.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

PART-TIME LOCUM in Beautiful Suburban Clinic. Hours arranged to suit. General and E.R. Practice. Liberal Hourly Salary. Write: G. A. Caress, 2320 W. High Street, Blue Island, Illinois 60406, or Call (312) 388-5500.

GASTROENTEROLOGIST WANTED for beautiful multi-specialty clinic in south suburbs of Chicago. Must be licensed in Illinois. Write: Mr. G. A. Caress, 2320 W. High St., Blue Island, Ill. 60406 or Call: (312) 388-5500.

INDUSTRIAL PHYSICIAN: Unusual opportunity for doctor interested in Industrial Medicine and performing minor traumatic surgery; clinic located southwest side of Chicago. Starting salary \$35,000. Doctor can only go up from this base. Write P.O. Box No. 812, c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

A BETTER PLACE TO PRACTICE MEDICINE—For those who would prefer to live in a warmer climate, avoid the big city school, traffic and practice problems; contact this multi-specialty group, located in a city of 100,000 people in North Central Texas. Specialists in Internal Medicine, Family Practice, Pediatrics, General and Orthopedic Surgery are needed to complement the current staff of twenty-one full time physicians. Contact: Wichita Falls Clinic-Hospital, 1300 Eighth, Wichita Falls, Texas 76301.

WANTED: PHYSICIANS, SPECIALISTS OR GENERALISTS, who want to discover Ozaukee County, Wisconsin. A beautiful blend, rural agricultural with many cities and villages growing and progressing but still preserving an Early American charm. This prime recreation area bordering Lake Michigan has a modern progressive hospital at Port Washington serving the population of 55,000 but short the necessary link—Physicians. Contact George Seidenstricker, St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone: 414-284-5511.

FULL TIME PHYSICIAN for Outpatient Department of Prepaid Health Plan. Five day 40-hr. week. No on call. Located in Central Illinois. New modern facility. Salary open. Tax shelter available. Contract administrator, Wabash Memorial Hospital Assn., 360 E. Grand, Decatur, Ill. 62525. Telephone: (217) 429-5246.

INTERNISTS: Prefer Bd. Cert. or Bd. eligible, opportunity for private, group practice. Offices, hospital based, newly constructed, plus renovated 200 bed, fully accredited acute care community hospital. Low overhead. Contact Administrator, Loretto Hospital, 645 S. Central Ave., Chicago, Ill. 60644. (312) 626-4300.

SHELL LAKE CLINIC, LTD., Shell Lake, Wisconsin, expanding to seven man group. Three family physicians and one surgeon desire additional **TWO FAMILY PHYSICIANS** and **ONE INTERNIST**. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call (715) 468-2711 or write to Clinic Manager, Darrell Bailey.

GENERALIST WANTED: for full-time student health position, 40-hr week, no on-call responsibilities, excellent community. Salary negotiable with liberal fringe benefits including 30-day vacation retirement plan. Illinois license. Write or call: Margaret M. Torrey, M.D. Illinois State University, Normal, Illinois 61761. Phone: (309) 438-8655.

Positions & Practice Opportunities (Con't)

PHYSICIAN FOR FAMILY PRACTICE—Our modern hospital located on the southeast side of Chicago is seeking a physician who is board eligible or a Diplomate of the American Board of Family Practice to establish a program in Family Practice and serve as its Director. A Fellow of the American Academy of Family Physicians is desired. Educational ties have been developed between our Hospital and the faculty of the University of Chicago Pritzker School of Medicine. You are invited to call or write: Dr. Bernard Lieb, M.D., Chief of Staff; Chairman, Intern & Resident Teaching Committee, South Chicago Community Hospital, 2320 East 93rd Street, Chicago, Illinois 60617; 312-978-2000.

PHYSICIANS to work full-time at one of various industrial sites in Midwest for a multinational company, which believes in promoting preventive medicine. **PLANT MEDICAL DIRECTORS** needed at some sites and an **INTERNIST** at one site. Excellent fringe benefit. Career opportunity. Write to Box Number 817, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Ill. 60601.

UNIVERSITY HEALTH SERVICE POSITIONS OPEN: General Practitioner, Pediatrician, or Internist, full-time, for Medical Clinic, General Practitioner, full-time or Gynecologist for office gynecology and family planning services. Psychiatrist, full-time, for patient therapy and to head Mental Health Unit. Modern facility, good fringe benefits. Illinois license required; salary per qualifications. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKalb, Illinois 60115.

ASSISTANT MEDICAL DIRECTOR—IDS Life, a subsidiary of Investors Diversified Services, is seeking an internist or general practitioner. This is an administrative position on the Minneapolis home office staff of a rapidly growing life and disability income insurance company. Primary responsibility is for the medical evaluation of insurance applications. Ability to interpret electrocardiograms is required. Position offers advancement potential, excellent benefits, profit sharing, and expenses for relocation to Minneapolis. Send resume in confidence to Dan Willius, 3300 IDS Tower, Minneapolis, Minnesota 55402.

PHYSICIAN FOR HEALTH SERVICES STAFF—immediate opening. 40 Hours per week plus night duty every 16th night. One Month Vacation and other Benefits. Equal Opportunity Employer. Salary to \$33,500 per year. Illinois License required. Appreciate full information first letter. L. M. Hursh, M.D., Director Health Services, University of Illinois, Urbana, Illinois 61801.

MEDICAL SERVICE STAFF PHYSICIAN—Board certification in Internal Medicine preferred. 200-bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Can pay moving expenses. License any state required. Equal Opportunity Employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46805, or call (219) 743-5431, Extension 310.

MEDICAL AFFAIRS DIRECTOR—Responsible for administrative and medical matters relating to patient care and affiliation with a School of Medicine. Must be licensed in Illinois and possess clinical experience in medicine and surgery plus supervisory and administrative capabilities. Excellent opportunity to join the administrative staff of a hospital expanding to 330-beds in Northern Illinois. Send detailed resume including salary, history to: P.O. Box No. 819, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

FOR SALE, LEASE OR RENT

FOR RENT: OPHTHALMOLOGIST OFFICE, 55 East Washington Street, Chicago, Illinois (Pittsfield Building). Available several days a week; fully equipped. Beautifully furnished. Phone: DE 2-4884/IR 8-8770.

ATTRACTIVE OFFICE FACILITIES immediately available. Large Reception Room with complete Paging and Message Services. Drug Store and Shops in busy Hotel Building. Adjacent parking, easy access to Eisenhower Expressway. Contact: Manager Oak Park Arms Hotel, Washington Blvd. at Oak Park Avenue, Oak Park, Illinois 60302. (312) 386-4040.

PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone 815-725-1188.

FOR SALE, LEASE OR RENT (Con't)

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

FOR RENT: Suites available in a recently completed Medical Center just 1/2 Mile from the new proposed Hospital in Barrington, Illinois. Each suite, 800 sq. ft., is elegantly finished and absolutely independent, incl. W/R, A/C, AM-FM, etc. Ample parking. Reply Box Number 815, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

FOR SALE: Lucrative and well established General Practice in southwest Chicago. Second floor office situated over pharmacy. Will introduce. J. Dudek, 3753 S. Honore, Chicago, Illinois 60609.

MEDICAL BUILDING & APARTMENT FOR SALE—in Rockford area. Fully equipped 8 room medical suite, 6 room apartment above with many inclusions, 2 car garage—15 parking spaces. On 1/2 acre lot. Call Adams Real Estate, 312-498-1100, 1656 Shermer Avenue, Northbrook, Illinois, for full details.

FOR SALE: Custom built 10-Rm house with 4000 sq. ft. of living space in Crawford Gardens, Oak Lawn, Illinois. Five min. from Christ Community, Little Company of Mary and Holy Cross Hospitals. 3 full baths, 3 extra large BR. Red roman brick with white Georgia marble trim and 12' Georgia marble FP. Radiant HW heat in floor & ceiling. Central Air; sprinkling system, nicely landscaped; with many other fine appointments too numerous to list. Low taxes, bldg. 10 yrs. old, must see to appreciate. Price about \$140,000. Make offer to owner. Call for appt. (312) 423-7527 or 424-7539.

Office Space Available, **4010 W. MADISON STREET, CHICAGO, ILL.** 1-2-3 Rm. Suites or larger, in first class fireproof heated building. Good cleaning service. Automatic elevators. Plenty of business here for Doctors or Dentists etc. Immed. Poss. Contact: R. M. Ryan Realtor Agent, phone: (312) 243-2727 or apply Office of Building.

FOR SALE: MINI-CLINIC (17 Rooms) 6545 North Ave., Oak Park, Ill. Quality one-story medical building—3 Deluxe suites. X-ray Room—Drug Room—Laboratory—Central air-cond. 50' adjacent parking lot . . . \$105,000. Phone: 626-7652 **LUCLIFF REALTORS**, 848-9240.

DIRECTOR of MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principle psychiatric teaching resource for the Medical College of Wisconsin has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employee fringe benefit program and salary. Send vita to.

**Edwin A. Mundy, Director
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FOR SALE, LEASE OR RENT (Con't)

Complete 1972 Model H.G. Fisher X-Ray, includes: 300 MA 125KVP solid state control panel with 1/60th second electronic timer; major and minor KVP control and line voltage control. 300 MA 125 KVP solid state transformer for single tube use. Floor to ceiling tubestand with magnetic locks and collimator. DX 40 rotating anode tube and mounting yoke for tubestand. Hand tilt table with recipromatic bucky on floor rails. Set up and serviceability guaranteed. \$4,000.00 off original selling price. Leasing arrangements available. Call Collect: Martin Fox or Dave Huck at (217) 529-6694.

Practices & Positions Wanted—Paramedical*

POSITION WANTED—EMERGENCY ROOM PHYSICIAN, experienced 28 years old, military completion August, 1973. Desires full or part time work in Chicago or southern Wisconsin area. Write P.O. Box No. 816, c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

A MULTIDISCIPLINE RESEARCH GROUP providing consultation advice and services in the areas of organizational development and evaluation. Evaluational Research Consultants International, P.O. Box 66587, O'Hare International Airport, Chicago, Illinois 60066.

RADIOLOGIST AVAILABLE: Diagnosis, incl. spec., procedures, Radiation, incl. supervoltage, and Isotopes. Part-time or ev. full time. Write: Box Number 811, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

PROGRAM EVALUATION CONSULTATION—Extensively experienced staff in OR, computer analysis, experimental design of evaluation strategies. Staff effectively deployed at low cost. **EVALUATION SYSTEMS**, 143 Point Bluff Drive, Decatur, Illinois 62521.

WAUKEGAN M.D. seeks Industrial Work School Health Programs, Insurance Examinations, Nursing Home Service. Available evenings and week-ends. Write to Box Number 818, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

NOTE:

*Professional qualifications of Paramedical Personnel are subject to review by prospective physician employers.

COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES—1973

SPECIALTY REVIEW IN SURGERY, Part 1, October 22
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, Oct. 22
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Oct. 1
BLOOD VESSEL SURGERY, One Week, October 8
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Nov. 6
DISEASES OF ESOPHAGUS, STOMACH & DUODENUM,
3 Days, Nov. 8
SURGERY OF GASTROINTESTINAL TRACT, One Week, Nov. 12
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 29
BASIC GYNECOLOGY, One Week, October 1
BASIC OBSTETRICS, One Week, October 8
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 26
BASIC ELECTROCARDIOGRAPHY, One Week, October 15
BASIC INTERNAL MEDICINE, One Week, October 22
ADVANCES IN INTERNAL MEDICINE, One Week, Nov. 26
FAMILY PRACTICE REVIEW, One Week, October 8
PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 30
RECENT ADVANCES IN PSYCHIATRY, One Week, December 3
BASIC DERMATOLOGY, One Week, October 15
STATE & NATIONAL BOARD REVIEW, Basic & Clinical,
Nov. 4 & 12
GENERAL PEDIATRICS, One Week, November 26

Information concerning numerous other continuation courses available upon request.

Address:

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100-101	Roche Laboratories <i>Dalmane</i>		

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160	Medical Protective/ <i>Professional Liability Insurance</i>	164	Parker, Aleshire and Company/ <i>Group Insurance</i>
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Services and Continuing Education

89-90	Blue Cross/Blue Shield	167	Milwaukee County Civil Service Commission
167	Cook County Graduate School of Medicine	102-103	Pharmaceutical Manufacturers Association
145	Illinois Foundation for Medical Care	167	Classified Advertising
92	INTRAV/ <i>Orient Adventure</i>	162-164	Physician Recruitment

STACKS

Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

VOL. 144 / NO. 3
SEPTEMBER, 1973



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Leadership Conference

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SEE PAGE 237

Healing nicely, but it still **HURTS**

HERE

Burns




When parenteral analgesia is no longer required, Empirin Compound with Codeine usually provides the relief needed.

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Sutures



Empirin Compound with Codeine is effective for visceral as well as soft tissue pain—provides an antitussive bonus in addition to its prompt, predictable analgesia.

 **prescribing convenience:** up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3**, codeine phosphate* 32.4 mg. (gr. ½); **No. 4**, codeine phosphate* 64.8 mg. (gr. 1). *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.



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EMPIRIN COMPOUND c CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
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BLUE SHIELD REPORT



FOR *Illinois Physicians*

Benefits for Disabled Under 65

The 1972 amendments to the Medicare law have been broadened to entitle some disabled individuals under 65 to have the same benefits offered by Medicare.

Blue Cross and Blue Shield responded by offering supplementary benefits to this new category of disabled beneficiaries if they are presently enrolled members.

When completing a Blue Shield Physician's Service Report please indicate if the patient is a Medicare beneficiary in addition to the Blue Shield group and subscriber number. Also indicate the service performed, the date of the service and the fee for that service. Blue Shield will pay directly to the physician its portion of the covered charges not paid by Medicare.

The following benefits are covered:

Blue Shield pays. . .

- 20% of the physicians' Usual and Customary fees for service in the hospital
- 20% of the physicians' Usual and Customary fees for minor surgery or accident care in the outpatient department of a hospital
- 20% of the physicians' Usual and Customary fees for radiation therapy when a hospital outpatient or when receiving treatment in the physician's office . . . including x-ray therapy, radium therapy or radioisotope therapy for cancer
- 20% of physicians' Usual and Customary fees for visits in an Extended Care Facility (Skilled Nursing Facility) while receiving Medicare benefits
- In foreign countries, Blue Shield will pay the physicians' Usual and Customary charges for covered benefits on the same basis as they are paid in the United States.

Blue Cross pays. . .

- The first \$72.00 of hospital charges per benefit period when a bed patient in a hospital
- \$18.00 per day of hospital charges during a hospital stay from the 61st day through the 90th day
- \$36.00 per day from the 91st through the 820th day in each benefit period if hospital care is required
- \$9.00 per day from the 21st through the 100th day of care in an approved Extended Care Facility (Skilled Nursing Facility)

- Outside the United States Medicare usually does not provide any benefits. This new Blue Cross-Blue Shield Plan pays as much as \$10.00 a day as long as 820 days, when a patient is in the hospital.

Concurrent Medical Care

When a patient is admitted to the hospital primarily for surgical or obstetrical care, additional benefits for concurrent medical care rendered by a physician, other than the surgeon or obstetrician, would be paid under most Blue Shield certificates if there are unusual circumstances and specialized medical care is essential to, and distinct from the surgical or obstetrical care. Allowances vary according to the type of Blue Shield certificate held by the member.

Some examples of eligible claims for concurrent medical care are as follows:

(1) The patient is admitted as a medical patient and treated medically for a period before being transferred to the surgical or obstetrical service. In such cases, the physician rendering medical care should bill Blue Shield for his services to the date of transfer;

(2) The patient is primarily a medical patient, and the surgery performed is a minor procedure or diagnostic in nature. In these cases, the physician rendering medical care should bill Blue Shield for the entire period of hospitalization;

(3) The patient develops a post-operative condition requiring specialized medical services. In these cases, the physician rendering medical care should bill Blue Shield from the date he enters the case to the date of completion of his hospital service;

(4) The patient has a medical condition requiring close supervision both pre- and post-operatively. In this case, the physician should bill Blue Shield for the entire period of hospitalization and describe in detail the condition of the patient.

Admission date, discharge date, diagnosis and the number of in-hospital daily visits made must be reported before claims can be paid. To avoid returning reports for additional information which delay payments, the questions on the Blue Shield's Physician's Service Report must be completed, e.g., "Was surgery also performed," and "If so, by whom?," even if all services performed were medical.

In most Blue Shield certificates payment for in-hospital medical care is limited to one visit per day.

Accepting Assignment of Medicare Benefits

When a physician accepts assignment of Medicare benefits, he must submit an SSA 1490 Request for Medicare Payment form to the Part B Medicare carrier. Accepting assignment means the patient and physician agree to have Medicare make the payment directly to the physician. The physician agrees to accept the reasonable charge as determined by Medicare as payment in full. He may bill the patient for any amount applied to the Part B deductible, 20 percent of the allowable charges and any charge for services disallowed as not covered. The Part B carrier will pay 80 percent of the reasonable charge over and above the \$60 deductible.

Meeting the Part B Deductible

Each year a new Part B deductible must be met by the patient. Under a Medicare amendment effective January 1, 1973 the deductible was increased from \$50 to \$60. Even if a person is not eligible for Medicare for the entire year, the full deductible must be met. There is, however, a "carry-over" provision in the regulations that applies to covered expenses incurred during the months of October, November and December. A charge of \$30 incurred in October, 1972, for example, may be applied to the 1973 deductible remaining to be paid. The maximum "carry-over" from the last three months of 1972 is \$50.00, leaving an additional \$10.00 deductible to be met for services rendered in 1973. If the entire deductible is satisfied prior to October of the calendar year, the entire deductible must be met in the new year, beginning January 1, 1973. The "carry-over" rule was established so that a beneficiary would not have to meet the entire deductible twice in a comparatively short period of time.

Accepting Assignment for Public Aid Recipients

The physician must accept assignment for a recipient of Public Aid. In filing for Medicare payment, the SSA 1490 form is completed in triplicate. Send the first copy of the SSA 1490 to your Medicare carrier, and the second copy to the Public Aid Office, Medical Administration, 425 South Fourth Street, Springfield, Illinois 62703. The third copy should be kept in your files.

Medicare will allow 80 percent of the reasonable charge after the annual \$60 Part B deductible has been satisfied. A copy of the Explanation of Medicare Benefits (EOMB) indicating payment or non-payment will be sent to the Public Aid office. Public Aid will match this EOMB with their copy of the SSA 1490 and adjudicate the claim to make payment under the provisions of the Public Aid law.

The Signature Requirement For Assignment

Before the claim can be processed the patient's signature must appear on the SSA 1490 Request for Medicare Payment form except under the following circumstances:

(1) When the patient is a Public Aid recipient he is not required to sign the form. The Public Aid number of the patient is noted on line 5, and on the patient's signature line the wording "Public Aid Patient" is either stamped or written by the physician or his office assistant.

(2) When a patient is unable to sign the claim form because of a mental or physical condition, the patient's name is shown on line 6 of the form, followed by the word "by" and the signature and address of the relative or approved representative explaining his relationship to the patient. A statement is also needed explaining *why* the patient was unable to sign the request.

(3) If a person cannot write his name, he may sign with the mark (X) on the signature line, but the name and address of a witness must also appear on the line.

(4) When a patient is deceased and the physician accepts assignment, line 6 may be completed by the physician indicating "Patient is deceased".

(5) A physician treating a patient over an extended period, who agrees to accept assignment, may obtain the patient's consent to assignment of unpaid bills for an anticipated period of treatment by having the patient sign a statement as follows:

"I request that payment under the Medical Insurance Program be made directly to Dr. _____ on any unpaid bills for the services furnished me by that physician during the period _____ to _____. The period should extend no longer than the close of the calendar year, and the statement should be attached to the original claim and be submitted in the usual manner. On subsequent claims, the physician should indicate: "This is a continuation of a course of treatment for which the patient's assignment was previously obtained." This statement should appear in the signature box.

Assignment Not Accepted

In cases where the physician does not accept assignment or when the patient has paid the bill, Medicare will make payment directly to the patient. In these cases, the physician should supply the patient with an itemized statement, or he may file for the patient by submitting an SSA 1490, Request for Medicare Payment form and indicate that he will not accept assignment.

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications** are listed above. **MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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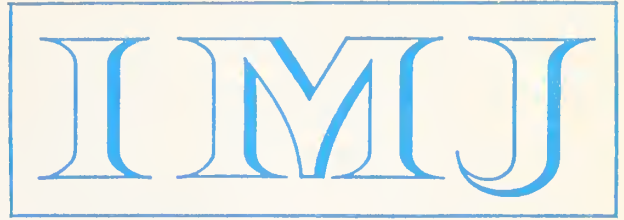


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Illinois Medical Journal

SEPTEMBER, 1973

Vol. 144, No. 3

CONTENTS

198 Abstracts of Board of Trustees Meeting

Special Articles

217 Continuing Medical Education and Professional Growth—
“The Physician’s Protection”

Thomas Meyer, M.B., B.Ch., F.R.C.P.

240 Herman von Helmholtz, 1821-1894—Physician, Musician and
Versatile Scientist

*E. Lee Strohl, M.D., Willis G. Diffenbaugh, M.D. and
Robert W. Jamieson, M.D.*

Clinical Articles

205 Surgery and Anticoagulation Therapy

*Raymond A. Dieter, Jr., M.D., Glen H. Asselmeier, M.D. and
Robert M. McCray, M.D.*

208 Celiac Artery Aneurysm

Robert DeBord, M.D., George Best, M.D. and Robert Wright, M.D.

222 Febrile Reaction of Gaucher’s Disease

Arthur A. Billings, M.D., Melvin Post, M.D. and Charles M. Shapiro, M.D.

Trauma Center

210 Illinois Emergency Medical Service System Status Report II

David R. Boyd, M.D.C.M. and Winifred Ann Pizzano, B.A.

Surgical Grand Rounds

227 Gunshot Wound of the Back

John M. Beal, M.D., Editor

(Contents continued overleaf)

CONTENTS (continued)

Features

- 182 President's Page
- 230 New Pharmaceutical Specialties
- 233 Doctor's News
- 238 Editorial
- 244 View Box
- 248 EKG of the Month
- 246 Pulse of the Doctor's Wife
- 250 Illinois Society, American Association
of Medical Assistants
- 258 Physician Recruitment

(Cover by Alicia Kolton)

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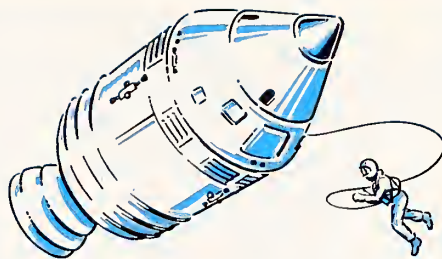
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Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . a prophylaxis to prevent kidney or bladder calculi.

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NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.



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Manufacturers of Ethical Pharmaceuticals

ROCHE announces new

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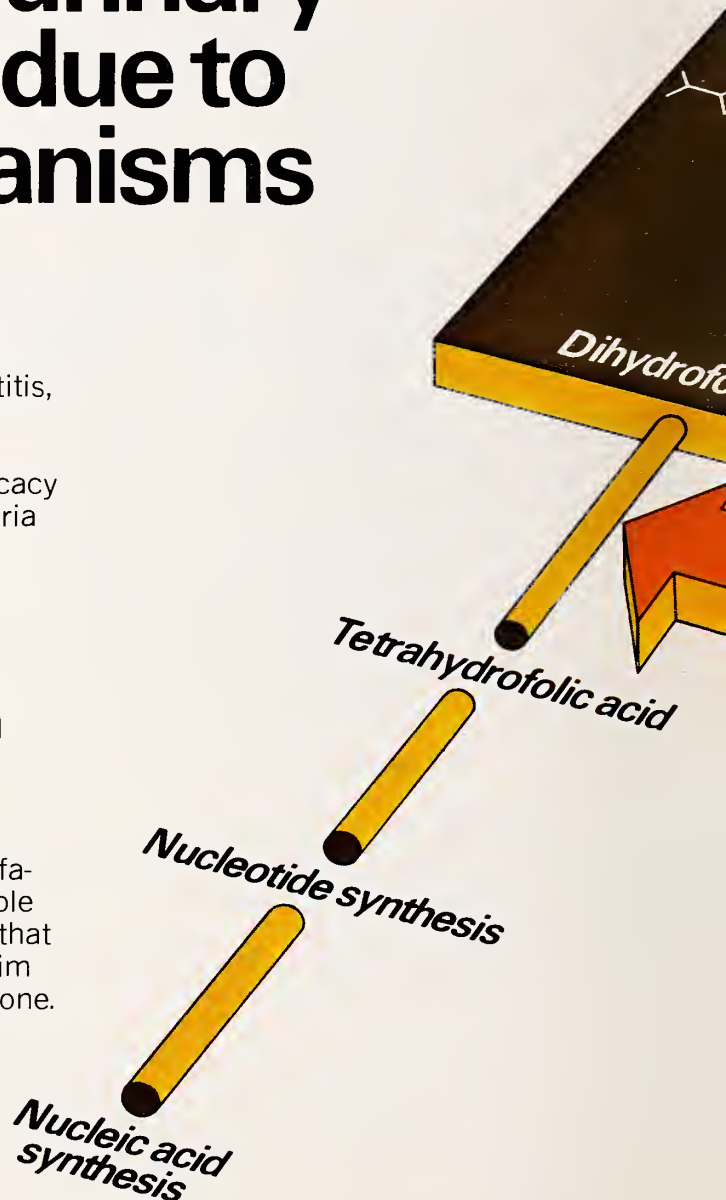
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

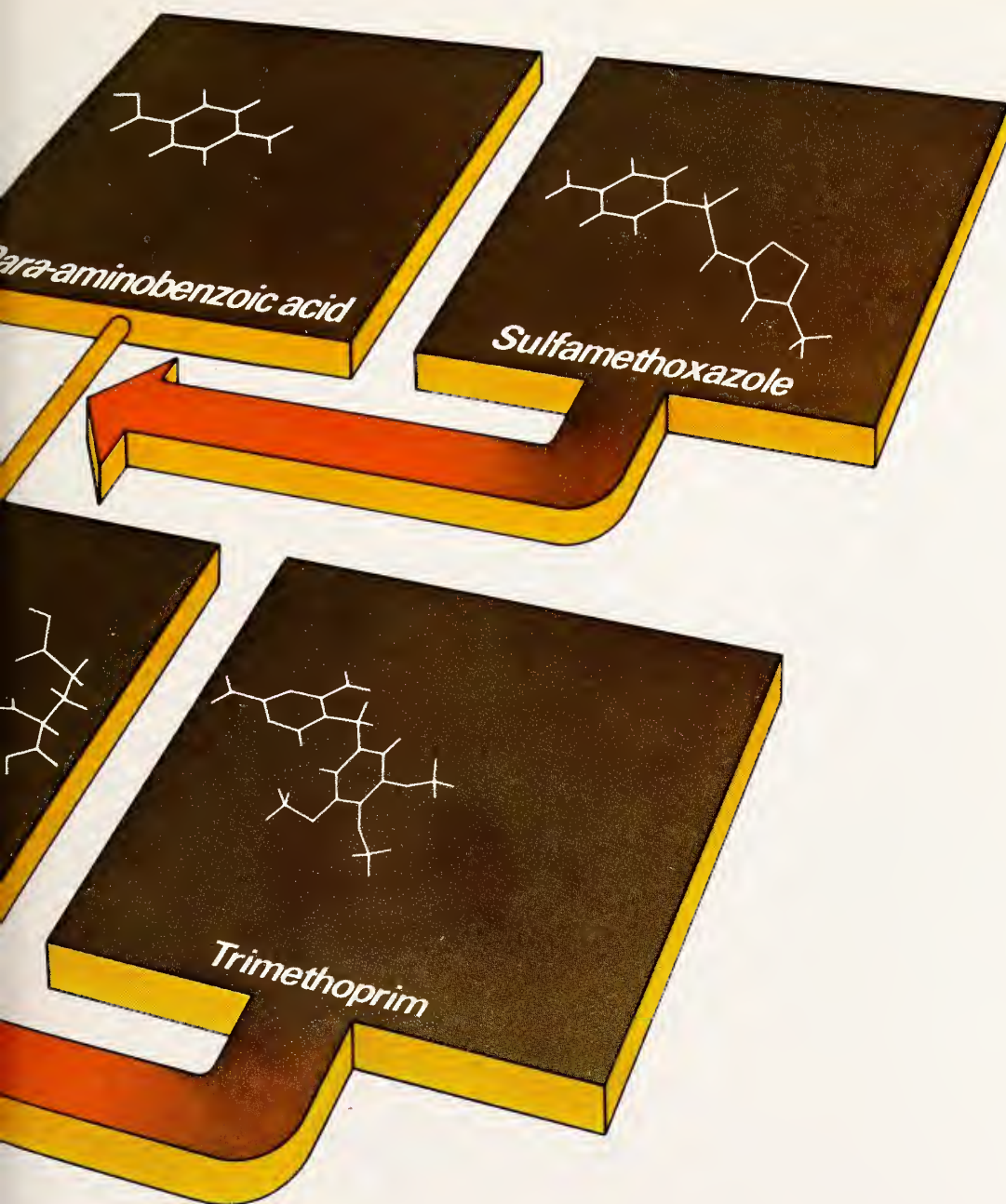
Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



Interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**TM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared

with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction — cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

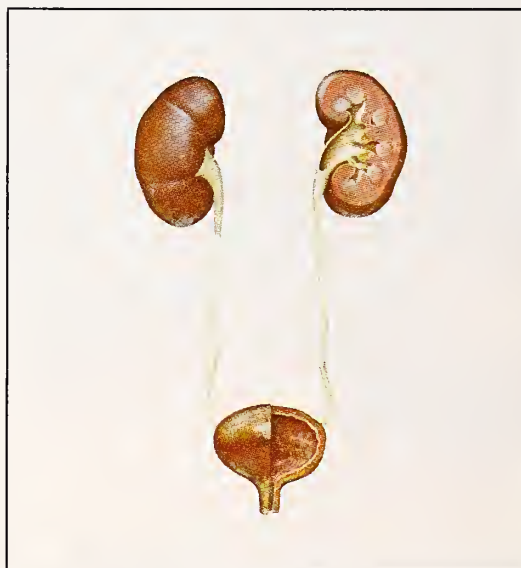
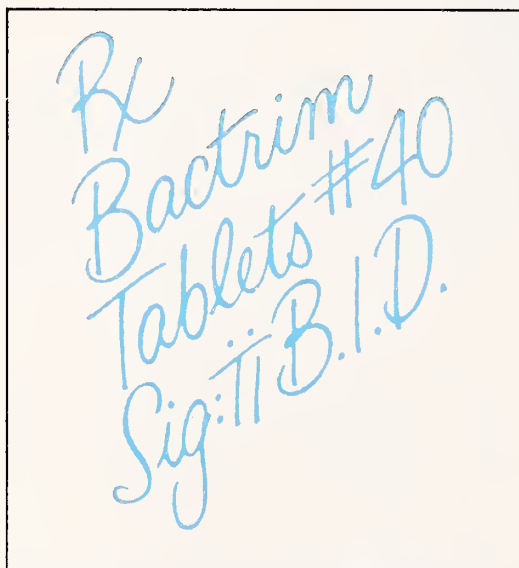
Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
† 4 patients not available for evaluation at day 10.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N¹-(5-methyl-3-isoxazolyl)sulfanilamide. It is almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Organism	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus spp.</i>	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. After repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma increases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together as Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

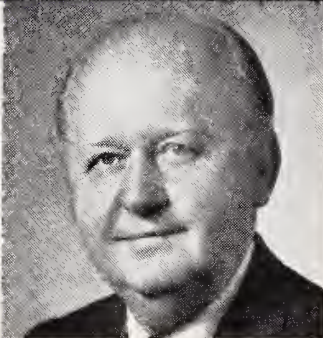
Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

uld be an obligation of medical
ctice...

"Medical societies ought to con-
t continuing campaigns to point
the substantial savings that could
ealized thru deductible insurance
protection for catastrophic ill-
s. At the very least, they should, in
patients' interest, question the
ics of any insurance organization
raises health care costs by forc-
policyholders to buy insurance
may not need or want and prob-
won't ever use.

"Too many doctors are indiffer-
to the economic consequences of
r decisions. Too many, for ex-
ple, habitually hospitalize patients
he convenience of the MD. It's
sense to deny such habits exist...

"Doctors, thru their medical so-
es, have unhesitatingly appealed
their patients for support in the
against government interference
the private practice of medicine.
the public in the past has re-
ded. It's time the American Med-
Association and state and local
ical societies paid off the debt by
sive action to hold down the cost
medical care."

Cost of Drugs

Insurance rates and hospital
charges are only two factors in health

care costs. The cost of drugs—both
prescription and nonprescription—is
another.

And when it comes to drug
costs, the nation's pharmacists *are*
concerned. Through their national
professional society, the American
Pharmaceutical Association, pharma-
cists are advising the public to use
nonprescription medication cau-
tiously and conservatively, and to seek
the advice of their pharmacist before
selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware
that when it comes to prescription
drugs, often he has an even greater
opportunity to reduce the cost to the
patient—with no sacrifice in the qual-
ity of the medication dispensed. But
in many states, outdated and anti-
quated laws prevent the pharmacist
from engaging in drug product selec-
tion. "Drug product selection" simply
means that the pharmacist functions
in the patient's interest by con-
sciously choosing, from the multiple
brands available, a low-cost quality
brand of the specific drug to be dis-
pensed in response to the physician's
prescription order.

Much *misinformation* has been
purposely spread by those who stand
to gain financially by maintaining

high drug costs to the public. An end-
less stream of propaganda has ema-
nated from the drug industry in an
effort to persuade the medical profes-
sion that these so-called anti-substitu-
tion laws should be retained. And as
long as these laws are retained, the
drug industry will continue its current
marketing practices which contribute
unnecessarily to high drug costs to
patients. These practices also are in-
viting government agencies to expand
their restrictive controls on physi-
cians and pharmacists.

APhA Efforts

As pharmacists, we are con-
cerned about health care costs. We
hope that every physician shares our
concern on this vital issue, and will
give his personal support to the con-
structive efforts APhA has undertaken
in the interest of all patients.

*(For a complete discussion of
drug product selection, you are invited
to request a free copy of the "White
Paper on the Pharmacist's Role in
Product Selection" from: American
Pharmaceutical Association,
2215 Constitution Avenue, N.W.,
Washington, D.C. 20037.)*

Drugs that he selects to treat the
majority of conditions encountered in
practice. Moreover, the physi-
cian's choice of a specific brand is
based on his knowledge of the pa-
tient's medical history and current
condition, and his experiences with
a particular manufacturer's
product.

Some substitution proponents
have argued that the dispensing of a
prescription is a simple two-party
transaction between the pharmacist
and the patient, and that a substitut-
ing pharmacist may avoid even a
technical breach of contract by simply
telling the patient that he is making
a substitution. I would judge that
the courts would be sympathetic
toward a pharmacist who substituted
without physician approval and who
undertook a legal defense that seeks
to make the patient responsible for
the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are
telling to the consumer, and par-
ticularly the consumer activist, that
reduced prescription prices could
follow legalization of substitution.
We have seen absolutely no evidence
to justify this claim. To the contrary,
experience in Alberta, Canada, where
substitution is authorized, suggests

the opposite.

Many pharmacists understand-
ably are concerned about the cost of
maintaining multiple stocks of similar
products. While there is no doubt that
inventory costs rise when additional
brands are stocked, it would be inter-
esting to know how much they rise,
and how many pharmacists actually
stock *all* brands—of, say, ampicillin
or tetracycline—or how long they
keep "slow moving" products on their
shelves before they are returned for
credit. To ask that the industry elimi-
nate multiple sources is to ask com-
petitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would
favor "corner cutting" pharmacists
and manufacturers. For them, free
substitution would be not a right, but
a license. As an aftermath, it is quite
likely that the confidence of both phy-
sicians and patients in the profession
of Pharmacy would be eroded, as
revelations about the unconscionable
behavior of an undisciplined few were
magnified in the press or in profes-
sional circles.

Summary

In short, what the American
Pharmaceutical Association advo-

cates as a broad-spectrum panacea
looks to us to be not only a minority
view (advocacy of substitution is by
no means a uniform policy in Phar-
macy), but also an extraordinarily
costly and ineffective remedy, whose
side effects are odious. We believe
(1) that an impressive majority of
pharmacists prefer to work with
Medicine and with industry, for the
consumer, and for the general good,
(2) that they seek the privilege to sub-
stitute when the patient might gain
and when the patient's doctor agrees,
and (3) that they seek to work for the
resolution of genuine grievances
openly and professionally.

*(For amplification of PMA views,
please write for our booklet, "The
Medications Physicians Prescribe:
Who Shall Determine the Source?"
It is available from: Pharmaceutical
Manufacturers Association, 1155
Fifteenth Street, N.W., Washington,
D.C. 20005.)*

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005





Much Ado— But Little Has Been Done

The need has been recognized . . . meetings have been held . . . petitions have been circulated . . . editorials have been written . . . referendums have been scheduled. . . .

But little has been accomplished!

More than two million Illinois citizens living in 43 counties still do not receive adequate public health protection because they have no local health departments. And the Illinois Department of Public Health reports that over 800,000 residents of 21 other counties are receiving only limited services. (See map)

Most local health departments providing limited services—such as home nursing care and screening programs—were formed by county board resolutions in 1966 to facilitate Medicare operations.

In addition to state and federal grants, these health departments rely upon the county's general fund for their operating budgets. But with all the demands for increased governmental services, health often receives a low priority when the tax dollar is distributed—making it difficult to fund a well-rounded program. Local funding has been further jeopardized by a provision in the new state constitution which abolishes a 3% tax collection fee paid to local taxing bodies.

Local health departments must have a tax base to provide a wide range of services such as prenatal care, mental health and physical therapy programs; inspection of food processing, drinking water and sewage disposal, and numerous other environmental programs.

Taxpayers, however, have shown a growing reluctance to vote for anything which would increase taxes. Last November, seven counties

voted in referendums which would have assured continuation of present levels of service and expansion to meet future needs.

Only three proposals passed!

The annual tax levy for local health departments is prohibited by law from exceeding \$1 per \$1,000 assessed valuation. That's a mere \$10 per \$10,000—about the price of two cartons of cigarettes! And in many counties the tax levy would be even less.

Voters also ignored a much-publicized Department of Public Health regulation, now rescinded, which would have denied state and federal grants to nonreferendum health departments after 1974 and further limited or possibly abolished existing services.

The public simply hasn't been sold on the importance of preventive medicine and public health!

Will we witness the same results at the polls in 1974 when 19 counties are expected to vote on health department proposals?

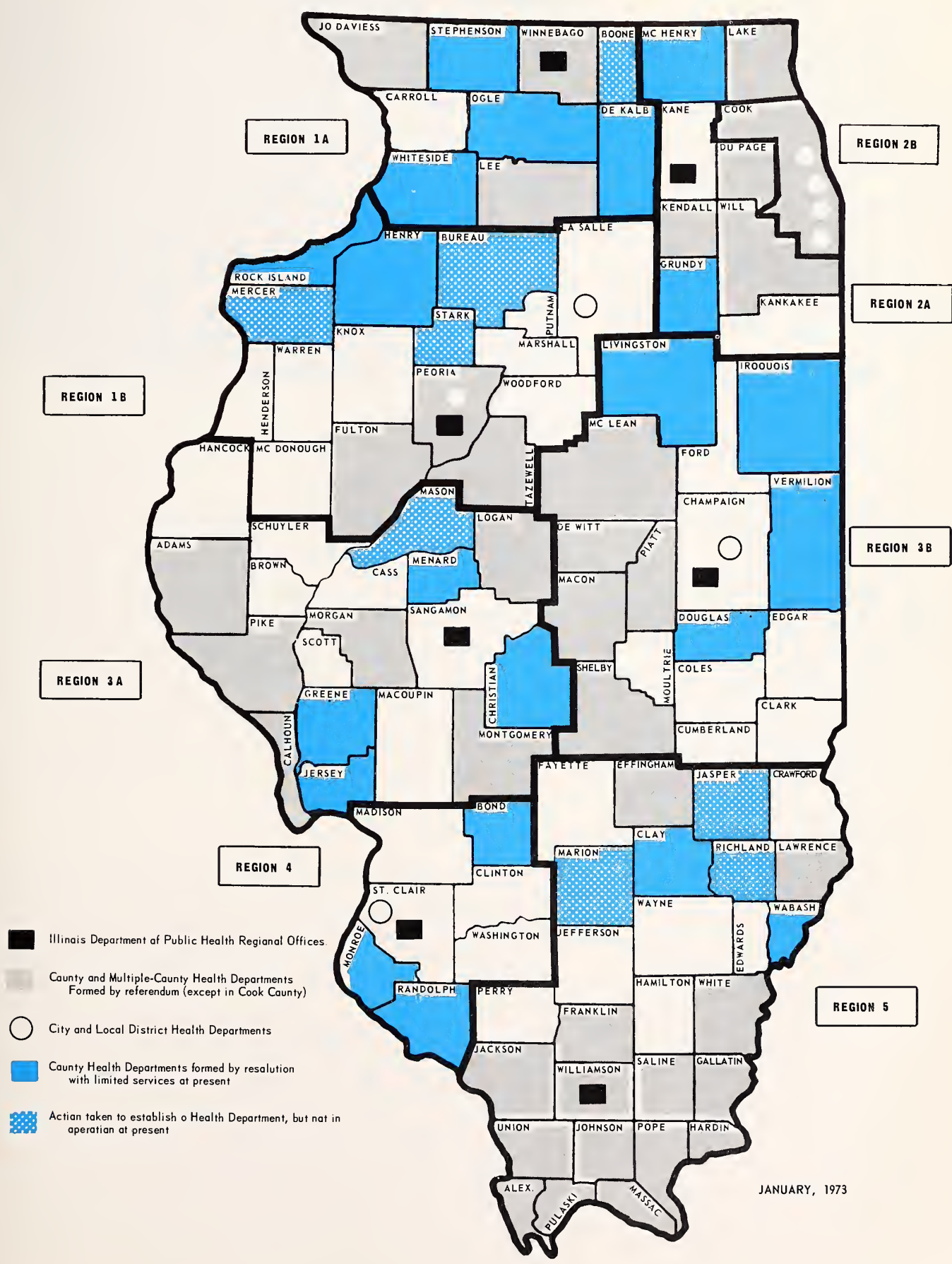
Our House of Delegates unanimously declared in 1969 that public health departments should be established throughout the state and that county medical societies should support their development. County societies backed the referendum proposals last year, but obviously there is a need for more physician involvement.

Concerned citizens and organizations already are working in many counties to generate support for 1974 referendums. But they need medical leadership—leadership only YOU can provide. ◀

William C. Scriven M.D.

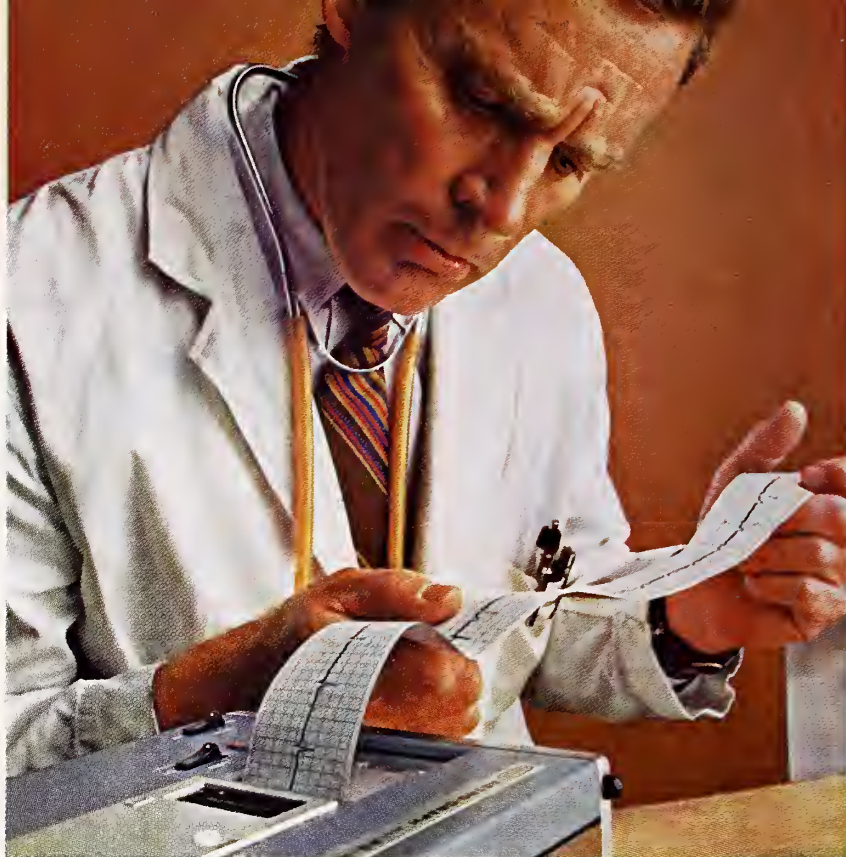
Unity + Strength = Effectiveness

HEALTH DEPARTMENTS IN ILLINOIS



JANUARY, 1973

When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions

organic basis and that reduction of excessive anxiety and emotional overreaction would be medically beneficial.

The benefits of antianxiety therapy

Antianxiety medication, when used to complement counseling and reassurance, should be both effective and comparatively free from undesirable side effects. More than 13 years of extensive clinical experience has demonstrated that Librium (chlordiazepoxide HCl) fulfills these requirements with a high degree of consistency. Because of its wide margin of safety, Librium may generally be administered for extended periods, at the physician's discretion, without diminution of effect or need for increase in dosage. (See summary of prescribing information.) If cardiovascular drugs are necessary, Librium is used concomitantly whenever anxiety is a clinically significant factor. (See Precautions.) Librium should be discontinued when anxiety has been reduced to appropriate levels.

For relief of
excessive anxiety
adjunctive

Librium® 10mg
(chlordiazepoxide HCl)
1 or 2 capsules t.i.d./q.i.d.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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for persons suffering from emotional illnesses. Psychological and physiological therapies provided for neuroses, psychoses, and psychosomatic disorders.

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intensive diagnostic evaluation and treatment.

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For Alcoholics

comprehensive and intensive therapy administered by a specially trained hospital staff.

J. Herbert Maltz, M.D., Medical Director

Chicago Lakeshore Hospital

4840 North Marine Drive, Chicago, Illinois 60640

(312) 878-9700



**Your experience has
shown you the benefits
of Lasix[®] (furosemide)
in initial therapy of
cardiac edema.**

Now...

(See prescribing information on last page of this ad.)

consider

LAAS

(FUROSE

in long-term



tablets
40mg

TM

X MIDE) therapy

wide range of effectiveness allows you to treat most degrees of cardiac edema.

dry weight can be reliably and safely maintained by adjusting the dose to fit your patient's needs. With doses exceeding 80 mg /day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

patient inconvenience is minimal since diuresis is usually complete within six to eight hours.

(See Lasix[®] [furosemide] prescribing information on last page of this ad.)

LASIX[®] (FUROSEMIDE)

TABLETS 40 mg



in long-term therapy

WARNING—Lasix[®] (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organo-mercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities, the drug is contraindicated in women of child-bearing potential.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix, children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients. Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium depleting steroids.

Frequent serum electrolyte, CO₂ and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix.

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion.

In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

When parenteral use of Lasix precedes its oral use, it should be kept in mind that cases of reversible deafness and tinnitus following the injection

of Lasix (furosemide) have been reported. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic dose of 1 to 2 ampuls (20 to 40 mg).

Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose, and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour post-prandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites. It has been reported in the literature that diuretics such as furosemide may enhance the nephrotoxicity of cephaloridine. Therefore, Lasix and cephaloridine should not be administered simultaneously.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue Lasix for one week prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, erythema multiforme, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, light-headedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

DOSAGE AND ADMINISTRATION—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced.

If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). The dose of Lasix may be carefully titrated up to 600 mg per day in those patients with severe clinical edematous states. Higher doses are currently under investigation.

The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg/day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

Hypertension—The usual dose of Lasix is one tablet (40 mg) twice daily both for initiation of therapy and for maintenance. Careful observations for changes in blood pressure must be made when this compound is used with other antihypertensive drugs, especially during initial therapy. The dosage of other agents must be reduced by at least 50 percent as soon as Lasix is added to the regimen to prevent excessive drop in blood pressure. As the blood pressure falls under the potentiating effect of Lasix, a further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary. It is further recommended, if one tablet (40 mg) twice daily does not lead to a clinically satisfactory response, to add other hypotensive agents, e.g., reserpine, rather than to increase the dose of Lasix.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

HOW SUPPLIED—Lasix (furosemide) Tablets are supplied as white, monogrammed, scored tablets of 40 mg in amber bottles of 100 (FSN 6505-062-3336), 500, and Unit Dose 100's (20 strips of 5) (FSN 6505-117-5982). Note: Dispense in dark containers. Exposure to light may cause slight discoloration which, however, does not alter potency.

PRINTED IN U. S. A. 3-73

Start with—
and stay with Lasix[®] (FUROSEMIDE)



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PHARMACEUTICALS, INC.
SOMERVILLE, N.J. 08876

Physicians like the kind of prescriptions we write.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

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Clinics Listed For Crippled Children During October

Thirty-two clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and three for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- October 2 Quincy—St. Mary's Hospital
- October 3 Springfield Pediatric-Neurological
Diocesan Center
- October 3 Rock Island Cerebral Palsy—Founda-
tion for Crippled Children and
Adults
- October 3 Hinsdale—Hinsdale Sanitarium
- October 3 Metropolis—Massac Memorial Hos-
pital
- October 4 Lake County Cardiac—Victory Me-
morial Hospital
- October 4 Sterling—Sterling Community Hos-
pital
- October 4 Flora—Clay County Hospital
- October 8 Peoria Cardiac—St. Francis Chil-
dren's Hospital
- October 9 Peoria—St. Francis Children's Hos-
pital
- October 9 E. St. Louis—Christian Welfare Hos-
pital
- October 9 Carrollton—Boyd Memorial Hospital
- October 10 Champaign-Urbana—McKinley Hos-
pital
- October 11 Kankakee—St. Mary's Hospital
- October 11 Rockford—St. Anthony Hospital
- October 11 Springfield—St. John's Hospital
- October 11 Cairo—Public Health Department
- October 12 Chicago Heights Cardiac—St. James
Hospital
- October 15 Peoria Cardiac—St. Francis Chil-
dren's Hospital
- October 16 Rock Island—Moline Public Hospital
- October 16 Mt. Vernon—Park Avenue Baptist
Church
- October 17 Chicago Heights—St. James Hospital
- October 17 Springfield Pediatric-Neurological—
Diocesan Center
- October 18 Elmhurst Cardiac—Memorial Hospi-
tal of DuPage County
- October 18 Bloomington—Mennonite Hospital
- October 23 Peoria—St. Francis Children's Hos-
pital
- October 24 Aurora—St. Joseph Mercy Hospital
- October 26 Evanston—St. Francis Hospital
- October 26 Chicago Heights Cardiac—St. James
Hospital
- October 30 E. St. Louis—Christian Welfare Hos-
pital
- October 30 Danville—Lake View Hospital
- October 31 Centralia—St. Mary's Hospital

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

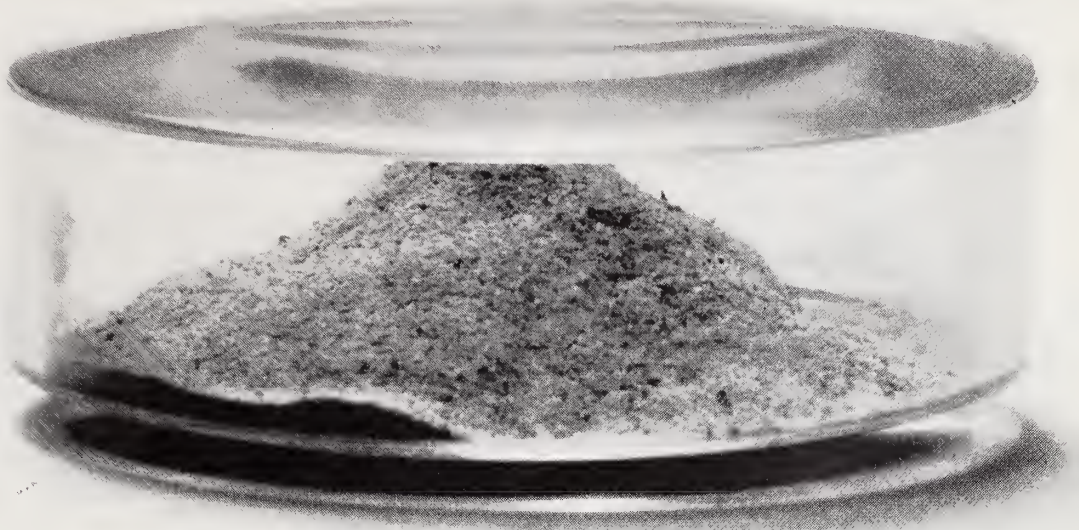
Full information available on request.



WARNER/CHILCOTE
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?



Unlike U.S.P.
desiccated thyroid,
Proloid® (thyro-
globulin) offers
the assurance of
constant potency.
To begin with,
Proloid is uniquely
purified. The

thyroglobulin extracted from hog thyroid is devoid of any glandular debris.
Then, Proloid is chemically and biologically assayed to assure consistent
metabolic activity from batch to batch. The T_4 and T_3 content of every dose is
blended for optimal thyroid replacement.

Important, too, is the fact that Proloid is invariably "fresh" when your patients
take it. Under proper storage conditions, its potency will not diminish for at least
four years.

All of which adds up to this: the potency of Proloid is constant...for more
consistent results.

PROLOID® **(thyroglobulin)**

natural thyroid therapy
that leaves
nothing to chance

THE NATURAL WAY

For more than thirty years
PREMARIN (Conjugated Estrogens
Tablets, U.S.P.) has been
prepared with natural equine
estrogens exclusively—without
synthetic estrogen supplements.

For more than thirty years it
has provided the complete estrogen
complex in the proportions found
in its natural source. And for more
than thirty years PREMARIN has
enjoyed an unparalleled record of
clinical efficacy and acceptance.

PREMARIN. The only estrogen
preparation available that contains
natural estrogens exclusively and also
meets all U.S.P. specifications for
conjugated estrogens. Assurance of
quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY

(For full prescribing information, see package circular.)

PREMARIN®

(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. "Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating

breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement

reactivation of endometriosis

possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males

edema

aggravation of migraine headaches

change in body weight (increase, decrease)

headache

allergic rash

hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

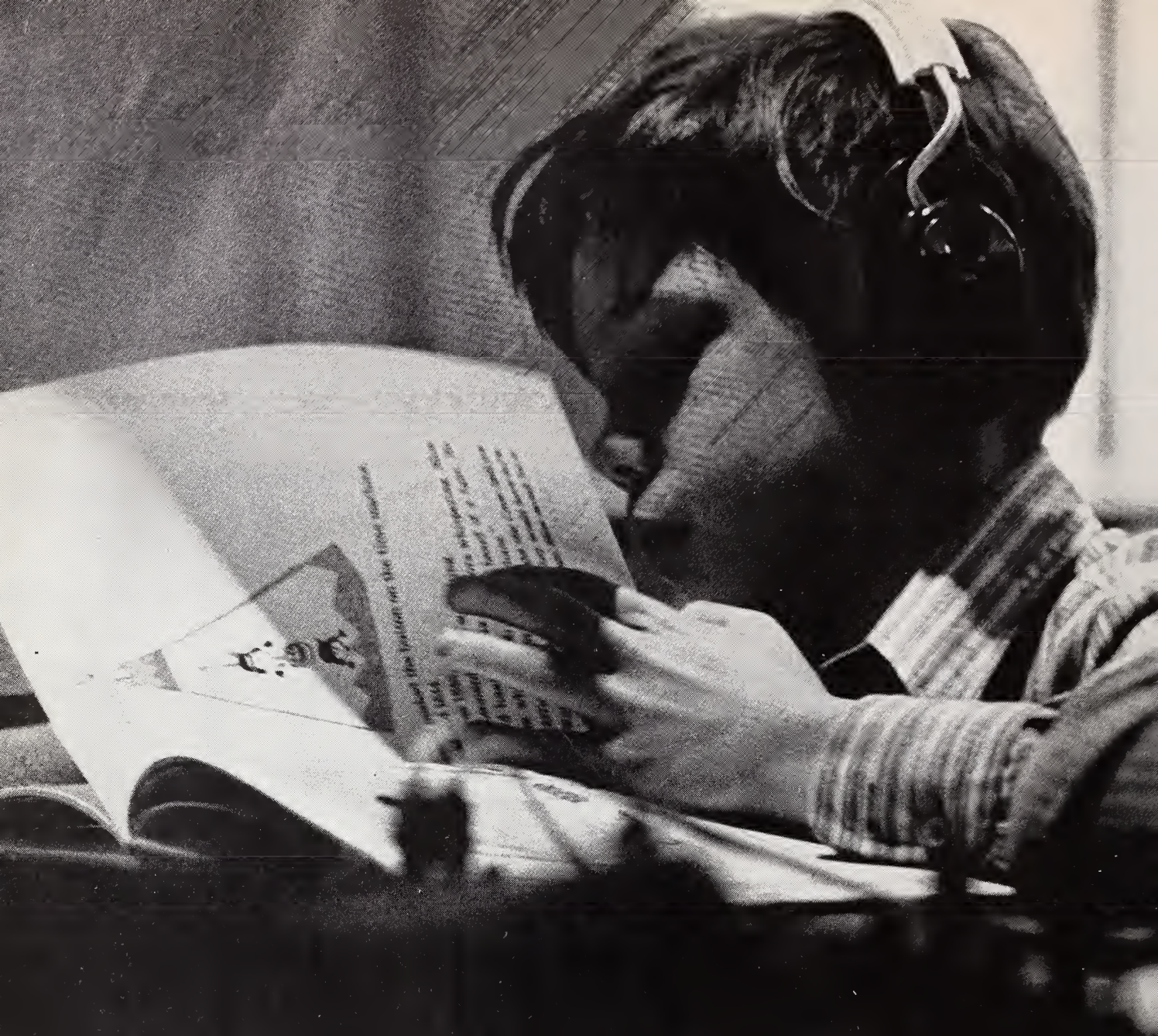
BRAND OF

CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY
NATURAL ESTROGENS
...NO SYNTHETICS
OR SUPPLEMENTS

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

— first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

'Wednesday's child is full of woe'

It need not be this way for the MBD child.

He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD—Minimal Brain Dysfunction—can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.¹

Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference
L. Charlton, M. H.: *NY State J Med* 16:2058 (Aug 15) 1972.

Ritalin® hydrochloride © (methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)
Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.
Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available.
Although a causal relationship has not been established, suppression of growth (ie, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without

prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been

reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (eg, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug. Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

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Ritalin®
(methylphenidate)
only when medication
is indicated

C I B A



Abstracts of Board of Trustees Meeting

July 14-15, 1973

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Leadership Conference

The 1973 Leadership Conference will be held Sunday, October 21, at the Drake Hotel in Chicago, with a half-day session devoted to legislation and the remainder of the program given to a subject of equal importance, such as PSRO. The Board voted to accept financial assistance from Smith Kline and French for a luncheon and program in connection with the conference.

ISMS to Receive \$5,000 Grant

An Interstate Postgraduate Medical Association of North America grant of \$5,000 is to be used to finance an Illinois Council on Continuing Medical Education project involving family physicians. Details will be worked out in a meeting between officers of the Educational & Scientific Foundation, which will receive the grant, and representatives of Interstate.

Board to Meet During Washington Roundup

For the first time, the Board of Trustees will conduct one of its regular meetings in conjunction with the Washington Roundup, an annual event designed to familiarize ISMS members with the national government. Tentative schedule calls for the Board to meet February 3 and 4 in Washington, D.C. preceding the traditional roundup activities which will be followed by an optional, personal expense trip to a Caribbean island. The "Roundup" and island excursion will be open to all ISMS members who will receive full details when available.

Nominations for AMA Councils and Committees

ISMS is nominating the following for positions on AMA councils and committees:

Robert Hartman, M.D., Jacksonville, Committee on Maternal and Child Care; Max Klinghoffer, M.D., Elmhurst, Physician Advisory Committee on TV, Radio and Motion Pictures and Bernard R. Cahill, M.D., Peoria, Committee on Medical Aspects of Sports.

The nominations of Donald Stehr, M.D., for the Council on Rural Health and Edward A. Piszczek, M.D., for the Council on Environmental, Occupational and Public Health were forwarded to the AMA previously.

Physical Examinations by Paramedics

The Board authorized a press release summarizing ISMS policy on multi-phasic screening. Interest in the policy developed following recent publicity indicating the extent to which insurance companies are using paramedical personnel to conduct physical examinations. According to the July 6 "Action Report," over

300,000 such exams were performed last year and the figure is expected to double in 1973.

Classification of Barbiturates

ISMS will inform the Federal Bureau of Narcotics and Dangerous Drugs that it opposes the proposed transfer of nine derivatives of barbituric acid and their salts from Schedule III to Schedule II. According to Joseph Skom, M.D., ISMS Trustee and member of the AMA Committee on Alcoholism and Drug Dependence, the proposal would make it difficult for patients to refill legitimate prescriptions for amobarbital, butabarbital, cyclobarbital, heptabarbital, pentobarbital, probarbital, secobarbital, talbutal and vinbarbital.

Acute Manpower Shortage in Cairo

Following the appearance of Mark Lepper, M.D., the Governor's Health Care Coordinator—who described efforts to relieve the acute manpower shortage in Cairo—the Board offered to aid state officials and medical colleges trying to solve the problem. It was reported that St. Mary's Hospital in Cairo will close August 31 because there is only one full-time doctor remaining in the area.

Medical Assistants

ISMS will encourage county medical societies to assist the Illinois Chapter, American Association of Medical Assistants, in organizing county branches. The Board expressed appreciation to Mrs. Norma Domanic, Illinois Chapter President, for the efforts of medical assistants during the last legislative session.

Revised Budget Approved

The Board approved a revised 1973 budget presented by the Finance Committee. The budget, which was revised to incorporate the more current financial requirements of the society, remains balanced.

Blue Cross and Planning Agencies

The Board went on record as opposing a Blue Cross of Chicago action which could halt payment of provider contract rates to hospitals that proceed with capital developments without approval of state planning agencies. The Board said the Blue Cross action is contrary to ISMS policy which requires physicians to be involved at the local level in planning and developing medical programs.

PSRO

In accordance with Resolution 73M-44, which directed the Board to create a unified PSRO plan for Illinois, ISMS will establish the Illinois Professional Standards Review Organization as a non-profit corporation with membership open to all licensed medical and osteopathic physicians regardless of their affiliation with other organizations. The federal government will then be petitioned to recognize this corporation as the official area PSRO.

Now that information on PSRO is becoming available from Washington, ISMS will set up district meetings in the state to disseminate it.

Councils and Committees

Health Care of the Poor and Rural Problems is the new name for an ISMS committee reflecting the expanded area of activity for an existing committee called Health Care of the Poor.

To avoid confusion and misunderstanding, the Committee on Drugs and Therapeutics has been directed to obtain Board approval on all actions and recommen-

(Continued on page 261)

Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R^{*}

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

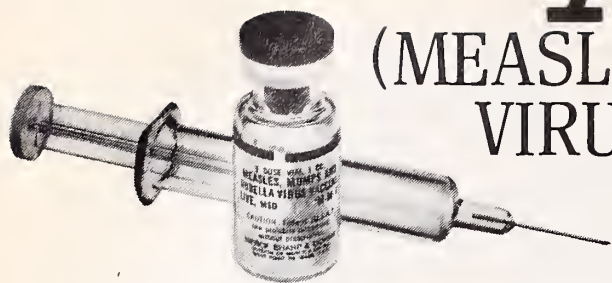
M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

^{*}Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.



M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK
SHARP &
DOHME

If you're ordering outside cultures for

bacteriuria

throat strep

gonorrhea

Candida (Monilia)

Staph aureus

*Pseudomonas
aeruginosa*

you can reduce errors caused by delayed incubation by switching to **Clinicult**TM

SKD's convenient, economical
office culturing system



With outside culturing,

unless each specimen is suitably handled during the interval between collection in your office and culturing in an outside laboratory, contaminants can multiply rapidly and delicate organisms may die.

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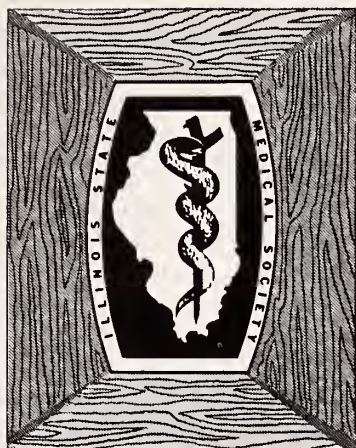
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Illinois Medical Journal

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Surgery and Anticoagulation Therapy

By RAYMOND A. DIETER, JR., M.D., GLEN H. ASSELMEIER, M.D., and ROBERT M. McCRAY, M.D./GLEN ELLYN

THE usage of both short and long acting anticoagulants has become widespread. Despite the frequent utilization of these anticoagulants, thromboembolism and its resultant embolic phenomena have continued to occur. The frequency and seriousness of these post-operative problems have warranted the increased usage of anticoagulant therapy in the surgical patient. Such techniques have proved most advantageous in the field of orthopaedics and especially in fractures of the pelvis and hips.¹ Similar programs have been utilized in general surgical patients with encouraging results.^{2,3} Therefore, it seems appropriate to discuss the subject of anticoagulation in the surgical patient.

Pre-Operative Evaluation

Prior to any surgical procedure, one of the simplest and most effective means of determining the presence of a bleeding dyscrasia is to question the patient regarding previous abnormal bleeding tendencies, either spontaneous or induced. Further, an attempt should be made to ascertain any family history of bleeding or coagulation difficulties. This method of screening will elucidate the great majority of potential problems and indicate that appropriate laboratory testing should be obtained prior to the

elective procedure. However, in a few, very young or very old individuals, severe defects may be present in the coagulation process and not have been previously manifested. As a result, many surgeons have made it a practice to have pre-operative bleeding and coagulation studies performed on tonsillectomies and cardiac patients. Simple screening procedures might include a bleeding, clotting, and prothrombin time. In addition, a platelet count and a partial thromboplastin time may be performed. The latter two may be most helpful.

Surgery universally produces an increased fibrinolytic activity in the patient. Usually this is short-lived and is not associated with excessive bleeding. The greatest increase in activity is observed in the prostatic surgical patient (plasminogen activator is increased and this might best be treated with epsilon aminocaproic acid); in thoracic surgical procedures (hypofibrino-

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genemia and hyperplasminemia), in obstetrics (hypofibrinogenemia), and in cardiopulmonary bypass (heparinization, defibrination and fibrinolysis all are present).

Transoperative Anticoagulation

Because of certain patients or groups of patients representing a high risk type of individual, pre-operative, operative and post-operative anticoagulation therapy may be indicated. Of particular note, one should consider the patient with a previous history of venous thrombosis or thromboembolism. In addition, the patient with varicose veins also seems to be of increased risk. There is no question that the obese patient and the patient who is in bed for more than three days have a greater tendency to venous thrombosis and embolization to the lungs. Also, the patient who has visceral malignancies, particularly carcinoma of the pancreas and patients who have pelvic dissections are more apt to have thrombotic processes develop. (Table I) The rationale for transoperative anticoagulation in these patients is four-fold: 1) Treatment of thromboses with pulmonary embolism is comparable to closing the barndoor after the horse gets out; 2) the prevention of the long term sequelae of the venous thrombosis such as milk leg or venous insufficiency; 3) prevention of post-operative thrombi, particularly on the mitral and aortic valvular prosthesis; and 4) improved results from vascular grafting proce-

dures for arteriosclerosis obliterans. Advocates of this technique vary in the method of therapy. One group utilizes Coumadin with the theory that you have decreased intravascular clotting without a change in hemostasis. They recommend twice/day prothrombin times or PTT and treatment with vitamin K₁ if prolongation occurs. The other group recommends heparinization with the theory that this is a readily controlled drug of short duration and protamine may prevent any bleeding problem. It is of interest that the patients who have the smaller procedure appear to have the greater tendency toward bleeding complications. This may be because they do not receive blood transfusions which counteract the anticoagulant. We notice, in a series of cardiac surgical patients, no essential difference in the amount of blood required for transfusion in the patients on pre-operative anticoagulants and those not on pre-operative anticoagulants (Table II). Both groups required an average of six units of blood to be transfused. There are, however, some contraindications to this technique. Included in these would be peptic ulcer and major bleeding sites; for example, GU tract and lung. Further, major injuries, especially those involving the brain, would dictate no anticoagulation therapy. Also, carcinomas, particularly of the GI tract, and portal hypertension seem to be relative contraindications.

Table I

PRE-OPERATIVE ANTICOAGULATION	
I.	Indications
a.	Thrombosis with P. embolism is too late
b.	Prevent long-term sequelae of venous thrombosis
c.	Improved vascular grafting results
II.	Method
a.	Coumadin group - decrease intravascular clotting without change in hemostasis - pro x or PTT BID Rx vit. K
b.	Heparin - readily controlled - protamine
c.	Minor OR: More bleeding secondary to overdosage as no blood transfusions
III.	Venous thrombosis - high risk - preop Rx
a.	Obese
b.	3+ days bed rest
c.	Visceral malignancy - esp. pancreas
d.	Pelvic dissection
e.	Previous history of varicose veins
IV.	Contraindications
a.	Peptic ulcer
b.	Major injury - esp. CNS
c.	Major bleeding - GU, GI, etc.
d.	Carcinoma
e.	Portal hypertension

Intra-Operative Anticoagulation

During surgery, there are a relatively large number of procedures performed which require the use of heparin. The great majority of these are cardiovascular procedures (Table III). The method of heparinization may be either regional or systemic depending on the type of procedure.

Table II

Pre-operative Anticoagulant Therapy Compared With Postoperative Blood Requirements		
Patient	Type	Units Transfused
2	Coumadin	8
5	Coumadin	2
6	Heparin	10
8	Coumadin	0
13	Coumadin	15
16	Coumadin	5
24	High ASA	3
25	Coumadin	5
28	Coumadin	6
Average		6

Table III**HEPARIN - Regional or systemic**

1. Carotid shunt
2. Cardiopulmonary bypass
3. Vascular occlusion
 - a. graft - esp. dacron
 - b. endarterectomy
 - c. Fogarty catheter
4. Auto-transfusion

For cardiopulmonary bypass, utilizing the heart-lung machine, a large percentage of surgeons use 2-3 mg./kg. of heparin intravenously. One-half the initial dose is then given each hour the patient is on bypass. At termination of the bypass procedure, the patient then receives one and one-half protamine/mg. of heparin in order to neutralize the heparin and obtain adequate hemostasis. The effectiveness of the neutralization may be measured by doing serial clotting studies in the operating room.

Essentially, all patients who have carotid endarterectomy, especially when using the Javid shunt, are heparinized systemically. In addition, the patients having an aneurysmectomy or a dacron graft bypass procedure are systemically heparinized. The majority of patients who have localized peripheral endarterectomy and Fogarty catheterization for thromboembolic phenomena, either arterial or venous, are systemically heparinized. Last, occasionally patients are encountered who have massive hemorrhage without the availability of bank blood. These patients may be systemically heparinized and the blood obtained from the chest or abdomen reinfused as an auto-transfusion. At termination of the procedure, the patient may or may not receive protamine. It is important to point out that one should routinely utilize heparin from the same company in order to be acquainted with the potential difference in units and effect of the drug.

Post-Operative Anticoagulation

Occasionally, one sees a patient in whom maintenance of the vascular channel following surgery seems to be in question. These patients may be maintained postoperatively on heparin or coumadin. We have, however, noted some problems with postoperative bleeding in this type of patient. In particular, hematomas of the wound have been seen. These have been noted following plication of the inferior vena cava, iliac endarterectomy and femoral grafting. Further, a leak at a vascular anastomosis may become apparent after closure of the wound

when the patient is maintained on anticoagulants. Hematomas following angiography in patients on heparin also have been noted. If the complication is of a serious nature, then one must consider the discontinuance of the anticoagulant. Dextran may be of benefit in this type of patient.

Embolic phenomena in the postoperative period must be treated aggressively, particularly if these are of a septic nature. If these are on the venous side, the usual source of such are from the pelvis or the lower extremities. Table IV presents current methods of therapy commonly utilized at this time. It should be pointed out that when one elevates the legs, one should not also elevate the head. This produces flexion at the hips with resultant venous stasis and possible formation of further clots. Initially, heparin is the drug of choice along with warm, moist packs and analgesics. Occasionally, phenylbutazone may be used and antibiotics would be of particular use in pelvic thrombophlebitis.

Table IV**Rx VENOUS THROMBOSIS**

1. Elevation - no flexion
2. Heparin - later coumadin
3. Analgesics
4. Warm, moist packs
5. Phenylbutazone TID
6. Antibiotics - in pelvic type
7. Dextran - decrease dumping
8. Surgery: embolectomy, thrombectomy, plication, ligate, screen
9. Lytic Agents
10. Jobst stocking

Dilemma

We have discussed the use of anticoagulants in the surgical patient—before, during and after surgery. However, there is always the problem patient that we encounter. A few of the problems which we have seen include a patient with a prosthetic mitral valve and an abdominal aortic aneurysm. Another patient had a bleeding duodenal ulcer and acute, deep thrombophlebitis. His sibling had expired recently from a pulmonary embolism. In another patient, a language barrier prevented adequate communication. Similarly, the patient who had four pulmonary emboli while on adequate anticoagulant therapy desired no surgery. Should any of the above patients receive anticoagulation therapy? If so, what type?

(Continued on page 252)

Case Report:

Celiac Artery Aneurysm

ROBERT DEBORD, M.D., GEORGE BEST, M.D., and ROBERT WRIGHT, M.D./PEORIA

Numerous papers have been presented dealing with the symptoms, radiological findings, and surgical procedures for the correction of celiac artery stenosis. However, celiac artery aneurysm is quite rare. Forty-two cases have been reported previously.¹⁻³ We were unable to find any other cases reported since the paper of Sweetman, et al., in 1966.

The purpose of this report is to present the clinical findings, method of diagnosis, and surgical repair of another patient with celiac artery aneurysm.

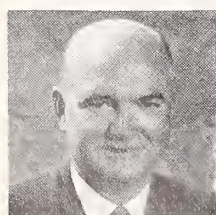
Case History

This 30-year-old white female first entered St. Francis Hospital in May, 1968. She entered for treatment of amebiasis acquired as a member of the Peace Corps in Bolivia. A colon X-ray revealed an abdominal calcification, first thought to be a bony tumor involving the twelfth thoracic vertebra. Subsequent films revealed this to be possibly a splenic artery aneurysm. (Fig. 1) The patient was treated with anti-amebic drug therapy and discharged in ten days.

She was treated for a urinary tract infection in 1969. In 1970, a D&C was done for spontaneous abortion.

She was admitted again in March, 1970, because of vague pain in the left side of the abdomen and for investigation of the aneurysm. Transfemoral aortogram was done on March 23, 1970. This revealed a celiac artery aneurysm. (Fig. 2) She was discharged the following day.

After considerable deliberation and consultation, the patient was admitted again to St. Francis Hospital for elective resection of the aneurysm. Physical examination was normal. The aneurysm could not be palpated. There was no bruit heard. She was operated upon on



R. A. DeBord, M.D.

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GEORGE BEST, M.D. and ROBERT WRIGHT, M.D. are from the Departments of Medicine and Radiology of St. Francis Hospital, Peoria and the Peoria School of Medicine.



Fig. 1: Oblique abdominal X-ray showing intra-abdominal calcification, thought to be a splenic artery aneurysm.



Fig. 2: Transfemoral aortogram showing celiac artery aneurysm with multiple collateral arteries from the superior mesenteric and good visualization of the hepatic and splenic arteries.

Aug. 31, 1970.

The aneurysm was dissected free without difficulty. The hepatic artery could be ligated proximal to the pancreaticoduodenal artery. The left gastric and splenic arteries and numerous small collateral vessels were ligated. The aneurysm was separated from the aorta by a fibrous diaphragm. (Figures 3 & 4)

The postoperative course was uneventful. She was discharged from the hospital ten days after surgery and has remained well.

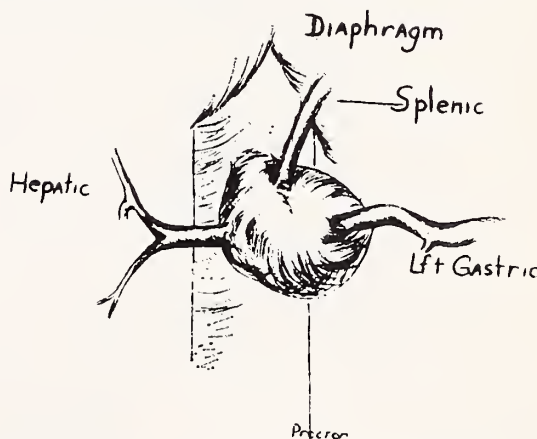


Fig. 4: Artist's drawing of aneurysm.

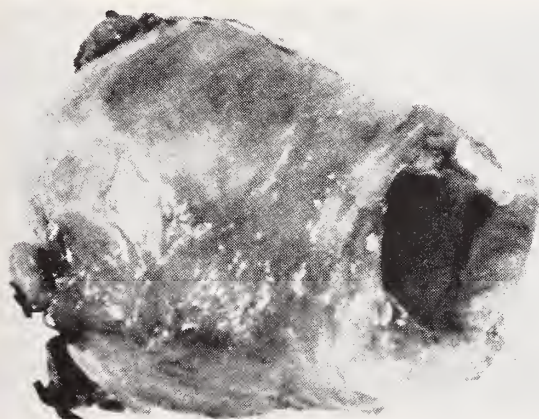


Fig. 3: Photograph of resected aneurysm.

Discussion

The danger of fatal hemorrhage from celiac artery aneurysm is great. In fact, 31 of the first 36 cases reported died from rupture of the aneurysm.⁴ For that reason, the patient presented in this report was advised to have surgical excision of the aneurysm, despite the absence of symptoms.

Prior to aortography, the diagnosis was seldom made before rupture. This represents the fourth case in which successful resection of the aneurysm was accomplished with the preoperative diagnosis established by aortography. All previous aortograms were done by the translumbar technic. We feel that retrograde transfemoral approach in the hands of a skilled radiologist is easier to perform and safer for the patient.

Some of the cases involve not only the celiac artery, but also the hepatic artery. Re-establishment of flow to the hepatic artery has been stressed by some authors.^{1,3} In this case numerous collaterals were present between the superior mesenteric artery and the hepatic artery. Simple ligation of the hepatic artery, splenic artery, and left gastric artery was sufficient.

It is thought that this patient first developed celiac artery stenosis and then post-stenotic dilation of the celiac artery. The dilated segment of vessel became larger. The aneurysm wall developed atherosclerosis. This later obliterated the lumen of the celiac artery at its junction with the aorta.

Summary

The 43rd case of celiac artery aneurysm is presented. It is the eighth case operated successfully. Transfemoral retrograde aortography for diagnosis is of great value.

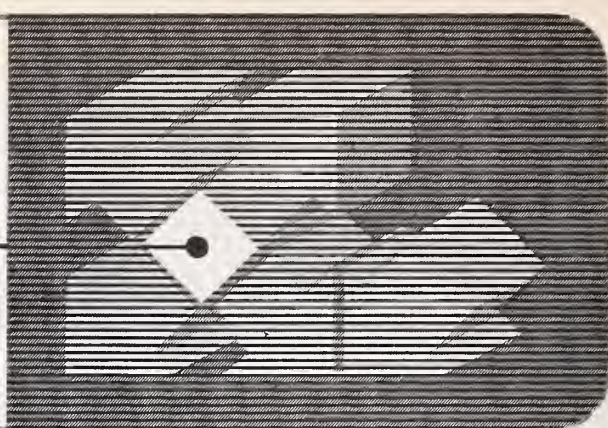
The danger of fatal hemorrhage in untreated cases is high. Surgical excision of celiac artery aneurysm should be advised, even in the absence of symptoms.

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Trauma Center

DAVID R. BOYD, M.D.C.M., Editor



Illinois Emergency Medical Service System* Status Report II (July, 1973)

By DAVID R. BOYD, M.D.C.M. and WINIFRED ANN PIZZANO, B.A.

Introduction

For some time it has been anticipated that improved trauma and emergency medical care could be obtained by a better organizational approach to this problem.

In Illinois, the development of a Statewide Trauma Program¹ has shown that the regionalization of expert care, which was previously available only in the university centers, can now be effectively and efficiently delivered throughout

the state, especially in the rural community. The initial success of the Trauma Program on a statewide basis has provided the groundwork for the development of a Total Emergency Medical Service (EMS) System in the State of Illinois.²

In July of 1971, the Illinois Trauma Program became operational. The program aimed at the development of some 45 hospital centers dedicated to the care of the critically injured patient which would be designated throughout the state and specially staffed and equipped to handle the complex needs of the critically injured patient. Initial funding for this program was from the National Highway Traffic Safety Administration (NHTSA) to provide the basic components for a network of interlocking trauma care centers. In July of 1972, the Division of Emergency Medical Services and Highway Safety was awarded a four million dollar demonstration contract by the Department of Health, Education, and Welfare to expand the trauma care system to all categories of emergent disease including trauma, cardiac, high risk infant, poisoning, drug overdose, and psychiatric emergencies. Subsystems of hospital categorization, communications, transportation, training and education,

Table I
Regional Trauma Centers

Established Trauma Centers

St. Anthony Hospital	Rockford	Region I-A
St. Francis Hospital	Peoria	Region I-B
Billings Hospital	Chicago	Region II
Christ Community Hospital	Oak Lawn	Region II
Cook County Hospital	Chicago	Region II
Evanston Hospital	Evanston	Region II
Foster G. McGaw Hospital of Loyola University	Maywood	Region II
Northwest Community Hospital	Arlington Heights	Region II
Northwestern Memorial Hospital-Wesley Pavilion	Chicago	Region II
St. Johns Hospital	Springfield	Region III-A
Burnham City Hospital	Champaign	Region III-B
Barnes Hospital	St. Louis, Missouri	Region IV
Doctors Memorial Hospital	Carbondale	Region V

Special Regional Trauma Centers

Children's Memorial Hospital	Chicago	Region II
Northwestern Memorial Hospital-Midwest Regional Spinal Injury Center	Chicago	Region II
University of Chicago Head Injury Center	Chicago	Region II



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*Supported in part by National Institutes of Health Grant NIH GM 18003-01, National Highway Traffic Safety Work Project (NHTSA), and Department of Health, Education, and Welfare Demonstration Contract HSM 110-72-345.

Table II
Areawide Trauma Centers
Established Trauma Centers

St. Mary's Hospital	Dubuque, Iowa	Region I-A
Moline Public Hospital	Moline	Region I-B
St. Mary's Hospital	Galesburg	Region I-B
Memorial Hospital of DuPage County	Elmhurst	Region II
Michael Reese Hospital	Chicago	Region II
Resurrection Hospital	Chicago	Region II
St. James Hospital	Chicago Heights	Region II
St. Joseph's Hospital	Joliet	Region II
St. Mary's Hospital	Kankakee	Region II
St. Therese Hospital	Waukegan	Region II
Blessing Hospital	Quincy	Region III-A
Decatur Memorial Hospital	Decatur	Region III-B
St. Elizabeth's Hospital	Danville	Region III-B
St. Joseph's Hospital	Bloomington	Region III-B
Memorial Hospital	Belleville	Region IV
St. Elizabeth's Hospital	Granite City	Region IV
Good Samaritan Hospital	Mt. Vernon	Region V

public education, and evaluation were to be strengthened and integrated into a total system for the delivery of emergency medical services in the State of Illinois (see Tables I, II, and III).

In the March, 1971 issue of the *IMJ*, "The Critically Injured Patient: A Plan for the Organization of a Statewide System of Trauma Facilities" was presented.³ The January, 1972 issue carried "Status Report: Illinois Statewide Trauma Care System."² Also published by the Illinois Department of Public Health was *The Critically Injured Patient - Concept and the Illinois Statewide Plan for Trauma Centers*, describing the plan in some detail.⁴ These and other articles in the "Trauma Center" section of this *Journal* were designed to inform the medical profession of program goals and progress.

The Illinois statewide system for trauma care is being further developed by integration of the following essential subsystems into a comprehensive whole: (1) hospital categorization;⁵ (2) communications; (3) transportation; (4) training and education of both professionals and the public; and (5) program evaluation.

In every major community and strategic geographic district the local Health Planning authority was asked to select the one hospital best suited for the care of the seriously injured. In

addition to this initial designation of a trauma center, all hospitals, professional and allied health personnel, and community leaders have started the task of integrating other subsystems into a comprehensive trauma care system by developing areawide Emergency Service Councils. Every hospital has self-categorized its capability for all aspects of emergency medical care as of July 1, 1973.

Hospital Categorization

Categorization has been identified as the essential first step to a true regional and competent trauma-EMS system. The goal of this approach is the continual upgrading of trauma and emergency medical capability in every community. This approach has produced other benefits including better cost effectiveness and improved resource utilization in those communities which are unnecessarily duplicating their efforts, monies, and medical manpower.

Table III
Local Trauma Centers
Established Trauma Centers

Community General Hospital	Sterling	Region I-A
De Kalb Public Hospital	De Kalb	Region I-A
Freeport Memorial Hospital	Freeport	Region I-A
Graham Hospital Association	Canton	Region I-B
McDonough County District Hospital	Macomb	Region I-B
St. Mary's Hospital	LaSalle	Region I-B
McHenry Hospital	McHenry	Region II
Lincoln Memorial Hospital	Lincoln	Region III-A
Passavant Memorial Hospital	Jacksonville	Region III-A
St. Francis Hospital	Litchfield	Region III-A
Memorial District Hospital of Coles County	Mattoon	Region III-B
Paris Community Hospital	Paris	Region III-B
St. James Hospital	Pontiac	Region III-B
St. Mary's Hospital	East St. Louis	Region IV
Pinckneyville Community Hospital	Pinckneyville	Region V
Richland Memorial Hospital	Olney	Region V
St. Anthony Memorial Hospital	Effingham	Region V
St. Mary's Hospital	Cairo	Region V
Doctors Hospital of Harrisburg	Harrisburg	Region V

Because of the progress already made in Illinois, the Hospital Licensing Board has ruled that the permissive categorization law passed in 1969 be made mandatory by July 1, 1973. This area-wide EMS legislation (Public Act 76-1858) requires that all acute care hospitals categorize their emergency capability into one of three levels: Comprehensive, Basic, or Standby.

In addition to categorization, hospitals must join an areawide plan for the delivery of emergency medical services. These planning areas are 25 miles in diameter in rural areas with at least one facility with 24-hour emergency room coverage. Each plan must show its system for handling the six identified categories of emergent disease and plans for transportation, communications, training and public education.

Presently there are 39 areawide EMS plans (10 are in metropolitan Chicago⁵) with 72 Comprehensive, 46 Basic, and 153 Standby facilities categorized. In Illinois, 118 hospitals have 24-hour physician coverage in emergency departments. It is anticipated that by 1974 there will be 129 (see Figure 1).

Emergency Medical Service Councils

Each EMS planning area relates to an Emergency Medical Service Council and is responsible for continued planning and coordination of all EMS activities for its area. These EMS Councils are being integrated in the local Comprehensive Health Planning Agency activity and involve a specified geographic area. The council itself is made up of EMS providers and consumers and is an umbrella group over more specific EMS activities with subcommittees on categorization, communications, transportation, professional and paraprofessional training, and public education.

The Areawide Hospital Emergency Service Committee for Categorization is made responsible by P.A. 76-1858 for development of hospital categorization and initiating the EMS plan. This committee has the required representation of hospital administration, medical staffs and nursing. Other subcommittees are now working in their respective areas to complete a total areawide EMS program.

Communications

The second highest priority in the Illinois Trauma System is the development of a comprehensive, uniform, simple, practical, and workable medical emergency communications capability. This will be by necessity pluralistic, and includes simple two-way radio voice, telephone patch,

dedicated phone lines, and in some instances microwave capabilities. The most important aspect of the communications subsystem is that it complements the medical needs of the entire system. It includes central dispatch and control of all mobile elements of the system. A medical resource guidance system is being developed for patient care advice, interpretation of bioelectrical data, and triage at the scene of the accident and during transportation to a designated treatment facility.

The medical communications design of the Illinois Trauma-EMS System is the Medical Emergency Radio Communications of Illinois (MERCİ). The MERCİ program has capitalized on existing resources and will provide a well-disciplined medical dispatch and control system for day-to-day emergency control and disaster response. The Illinois MERCİ System is being developed along established administrative regional patterns. These MERCİ Regional Communication Control Centers can now monitor ambulances in the entire region and physicians can be phone patched to ambulances for medical advice en route. The medical control unit at a regional (MERCİ) center can maintain up-to-date inventories of hospital bed capabilities, medical staff availability, blood supplies, and other medical resources. A MERCİ operations manual⁶ has been published and is now in use and available to assist users of the system.

Region III-A counties surrounding Springfield now have an operational MERCİ system. The telephone-radio 4-channel console is located at the Springfield Regional Trauma Center, St. Johns Hospital, where medical control is maintained. Radio base stations (hospital-to-hospital) are located at Decatur, Lincoln, Litchfield, Jacksonville, and Quincy and are intercom connected to St. John's by dedicated phone lines as well as with radios to maintain a complete regional communications network. All mobile ambulance radios in Region III-A can be assisted by a physician at a hospital base station or the regional communications center. Non-trauma hospitals are being integrated into this regional MERCİ network with 9 "hands free" telephone intercom systems.

In the recent airplane crash in St. Louis (July 23), all radio communications in the disaster area were monitored at the Springfield communications center via the radio telephone link to the Litchfield Trauma Center. This bi-state communications coverage provides for medical disaster backup to St. Louis in Springfield and could have been effectively mobilized from this

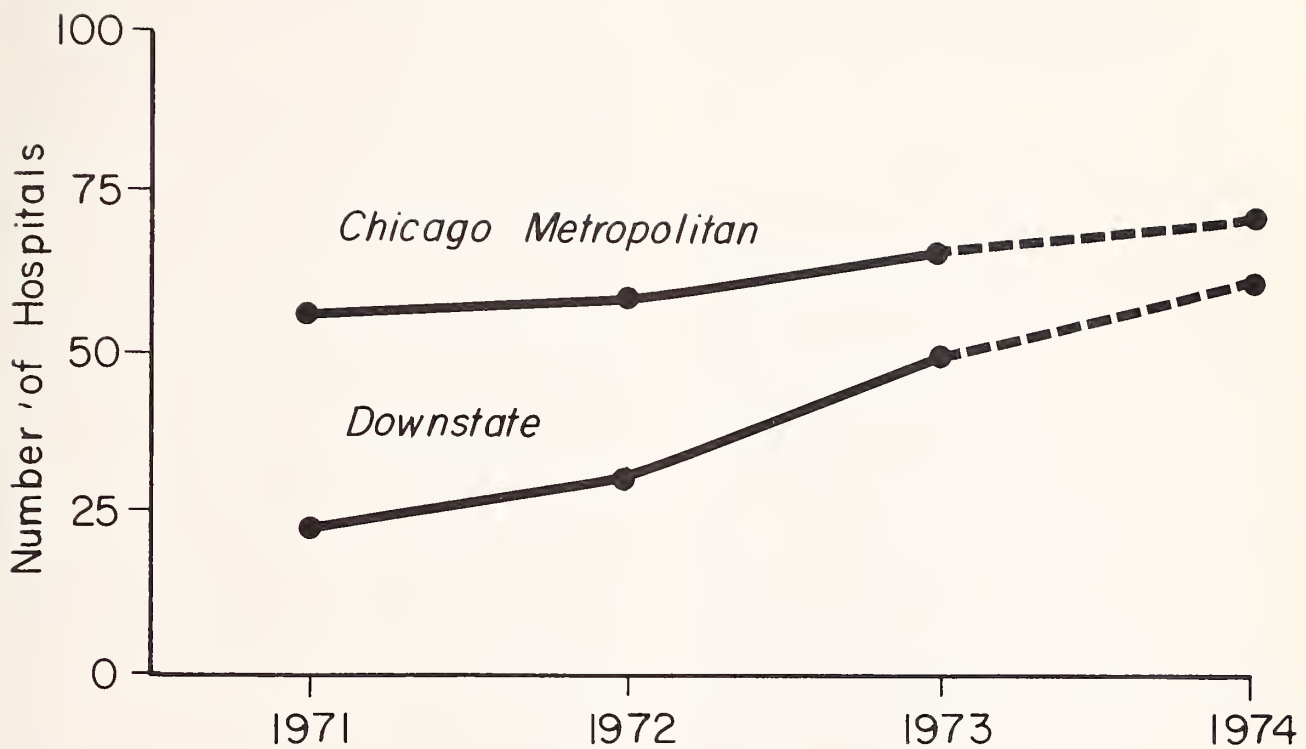


Figure 1. Annual increase of 24-hr. emergency department physician coverage. Note marked increase in downstate coverage. Much of this increase is in rural areas.

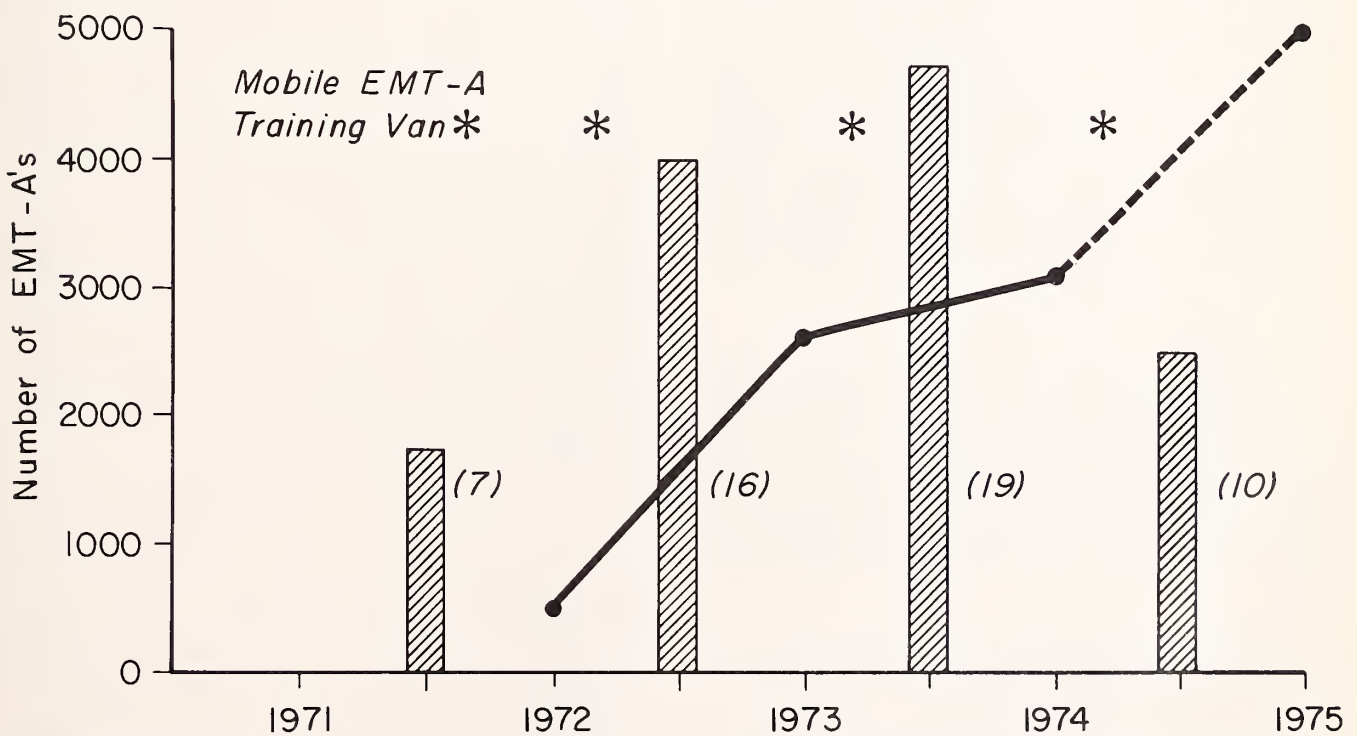


Figure 2. Bar graphs denote number of Trauma Center Hospital Emergency Medical Technician-Ambulance (EMT-A) teaching programs. Line graph shows number of trained and nationally registered EMT-A's. Projected goal for 1975 to exceed 5,000 EMT-A's trained to the basic 82-hour level. Asterisks note implementation of mobile teaching vans.

nearest regional medical center in case of need.

Completion of the statewide MERCI system is planned for January, 1975, with total hospital-to-hospital and hospital-to-ambulance coverage in every region.

Transportation

Primary Response System

Solutions to the problem of providing upgraded ambulance services must be stylized to meet the specific needs and capitalize on the existing resources of each community. In Illinois, the Trauma-EMS Coordinator⁷ is working with physicians, private ambulance operators, local governments, and municipalities to develop workable answers to what in many communities has been considered an "insoluble" problem. By identifying existing medical resources in community hospitals, colleges, industries, and even prisons, and by assisting in federal grant applications, the Trauma Coordinator has been instrumental in introducing ambulances of nationally accepted design criteria for the first time to many communities particularly in rural areas. Previously, many of these communities had no real comprehension of an acceptable ambulance.

As the Illinois plan for development of trauma care centers is based on the premise that not every emergency room can or should provide comprehensive care for the critically ill and injured, it is also axiomatic that not every community will be able to adequately sustain an ambulance service. Other solutions to providing such care are necessary and these are being explored. An overall statewide ambulance strategy has been developed to assist physicians, health planners and interested community leaders in the solution of their "local" ambulance problem.⁸

The Vienna Project

Vienna, Illinois (Region IV), is a small rural town with a population of 3,025 located in Johnson County at the southern tip of Illinois. Johnson and neighboring Pope County ambulance services had been provided by four independent funeral directors. Last year these morticians gave notice that they were discontinuing ambulance services.

Vienna has a minimum security prison with 24-hour medical dispensary. A plan was worked out by the Trauma Coordinator stationed at the Carbondale Regional Trauma Center to establish, in conjunction with this prison clinic, a 24-hour emergency ambulance service stationed at the prison and serving the bi-county area. This has provided approximately 11,500 people with

an around-the-clock ambulance service upgraded to national standards. This ambulance is dispatched from the regional radio center in Carbondale, or from the Local Trauma Center in Harrisburg or Cairo, and responds to emergencies in the immediate bi-county area. The medical personnel presently employed by the prison function as emergency medical technicians (EMT-A's) and drivers. An EMT-A training program has been sponsored by the town of Vienna in conjunction with the Vienna Prison using NHTSA matching funds. The program trains and utilizes both residents and interested community persons, and it provides a positive rehabilitation program at the prison and is a source of additional ambulance technicians.

Continued funding of this ambulance service by Pope and Johnson Counties has been administered by the Bi-County Commission. The commission has established a billing and collecting procedure and is responsible for ongoing service and maintenance of this program.

Secondary Response System

After a critically ill or injured patient is delivered to a small community hospital or a Local Trauma Center and is successfully resuscitated, a real dilemma exists. The second transfer is many times extremely difficult and its success is limited by available transportation resources and personnel. Often the level of care provided is far lower than that of the transferring hospital and the patient worsens during transfer. To partially solve this problem the Division of Emergency Medical Services and Highway Safety is developing Overland Critical Care Vans² which will be stationed at the Regional Trauma-EMS Centers. These vans will be equipped to provide specialized intensive care for patients while they are being transported to centers for specialized definitive care. The necessary professionals will travel with the patient and be trained in the applicable specialty—the use of equipment on the van and in intensive care of the critical patient.

Another component of the secondary transportation response system is helicopter evacuation used primarily for hospital-to-hospital transfers. Over one hundred missions were flown during the past year to support local physicians with critical trauma and seriously ill medical patients. Trauma Center heliports are now equipped with beacon lights for better night identification to improve the capability to a more comprehensive 24-hour service. Over the past year, some 48 fixed wing transfers were completed, mostly from southern and rural Illinois to specialized and Regional Trauma Centers.

Training and Education

Emergency Medical Technician-Ambulance (EMT-A)

The EMT-A course is an 82-hour nationally or state recommended basic training program for ambulance attendants. Over the past year, 3,600 persons have been trained as EMT-A's at 42 training centers. The course is taught by physicians assisted by Trauma Coordinators and under the auspices of Trauma Center Hospitals and community colleges. The course is free, and students may receive college credits. There are many positive reports by physicians and community leaders who attest to the improved care of the critically injured now being provided at the accident scene and during transportation. This EMT-A training program has been extremely well received in every Trauma Center Hospital and community (see Figure 2). A mobile EMT-A teaching van has already taken this program to several very rural communities (Rosiclare, Columbia, Brighton). The mobile teaching program will be expanded with two additional teaching vans. The total EMT-A training goal is to provide this basic level to over 5,000 ambulance attendants.

Advanced Emergency Medical Technicians (EMT-A II)

Under the provision of P.A. 77-2295, the "Mobile Intensive Care" law, the Division of Emergency Medical Services and Highway Safety now certifies hospitals to conduct pilot pre-hospital mobile intensive care programs. The law allows an EMT-A trained in advanced life support techniques to provide resuscitation, defibrillation, and life support treatments at the scene of an emergency when in radio contact with a physician or nurse. Mobile intensive care pilot projects are now underway at Northwest Community Hospital in Arlington Heights and the eight surrounding communities. These pilot programs will soon be started in Lake County, north Chicago, and Cook County.

Trauma Nurses

The Critical Care Nursing Program is now being offered at seven Regional hospitals. Already, 224 Illinois nurses have taken this formal four-week trauma-EMS intensive care course. Special instruction for burn and spinal cord injury nursing has been developed and initiated. Also, one- and two-day seminars for nurses are being offered across the state on the treatment of a variety of emergent disease including trauma,

neurological injuries, CPR, burns, disasters, drug overdose, and coronary care. Over 2,000 Illinois nurses have so far attended these courses.

Physician Education

Three emergency physician residencies have been initiated in Illinois (Evanston Hospital, Evanston; St. Francis Hospital, Peoria; and Billings Hospital, Chicago). The first two residency programs are developing with Department of Health, Education, and Welfare Demonstration Contract support. These programs utilize the curriculum guidelines of the American College of Emergency Physicians.⁹

Thirteen Critical Care Fellowships have been awarded to young medical professionals in several areas of the state for specialized studies in the various categories of emergent disease. The Fellows are involved in individual studies, program development, training of professionals and paraprofessionals and evaluation. Evaluation studies are in mobile cardiac and intensive care, central nervous system, chest, abdominal and extremity trauma.

A Trauma Workshop for Illinois physicians was recently held in Chicago. This two-day program was held to obtain maximal input for future trauma-EMS program development from Illinois physicians and surgeons. This input will involve future training and education efforts for trauma patient care, further developments of the regional patterns of trauma patient distribution, and the role of the various health agencies and professional associations in the overall Trauma Program. Special panels included discussions on: (1) emergency room planning and management; (2) clinical operative and patient management; (3) trauma-EMS systems management; (4) applications of trauma critical care; and (5) health agency and professional association involvement.

The April, 1973 issue of *The Journal of Trauma* featured a symposium on the Illinois Trauma System. Contributors from Illinois physicians reported on selected aspects of the Illinois Trauma-EMS Program. Titles and authors of the articles are listed below:

- "Introduction: A Controlled Systems Approach to Trauma Patient Care"—D. R. Boyd.
- "A Systems Approach to Statewide Emergency Medical Care"—D. R. Boyd, K. D. Mains, and B. A. Flashner.
- "Organization and Function of Trauma Care Units"—R. J. Lowe and R. J. Baker.
- "A Trauma Center in a Non-Metropolitan Community"—C. O. Metzmaker and R. Folse.
- "New Health Specialists for Trauma Patient Care"—

D. R. Boyd, K. D. Mains, T. L. Romano, and L. M. Nyhus.

"The Surgeon's Role in the Staffing of Hospital Emergency Departments"—R. J. Freeark.

"The Role of the Emergency Physician in a Trauma Center"—R. R. Hannas, Jr.

"Special Centers for the Care of the Injured"—P. R. Meyer, Jr. and J. G. Raffensperger.

"Trauma as a Component of a Critical Care System"—D. Allan.

"A Profile of the Trauma Registry"—D. R. Boyd, R. J. Lowe, L. C. Sheaff, C. Hoecker, and D. M. Rappaport.

The American Trauma Society

It is becoming more apparent that increased public awareness and support are needed to further improve trauma care across the nation. To fill this obvious need, a new lay-professional organization has been established.¹⁰

The American Trauma Society is a newly formed professional and lay voluntary organization that is being developed to forward the art and science of care of the accidentally injured and emergently ill. This volunteer health organization will initiate a broad program of public and professional education, training, research, and improved care in the field of accidental death and disability for all American citizens. The Illinois Division of this new Society has been chartered and will soon be underway in project activities and fund raising within the next year.

Principles of the American Trauma Society

The American Trauma Society will strive to bring together physicians, the ambulance profession, the insurance industry, safety engineers, public health officials, communications experts, medical scientists, law enforcement and fire protection professions, teachers, the press, the Armed Forces and other governmental agencies and particularly an informed and interested laity. These concerned groups and individuals, working together, will create programs in all spheres of scientific, clinical, and community endeavor and thereby meet the challenge of accidental injury.

Among the societies endorsing the association are: The American College of Surgeons, the American Association for the Surgery of Trauma, the American Academy of Orthopaedic Surgeons, and the American Medical Association.

Program Evaluation

A highway death study reported in the recent *Journal of Trauma* Symposium on the Illinois Trauma Program shows the effectiveness of the Trauma Program in central Illinois during the

first year of operation.¹¹ This evaluation of the highway deaths in a 15-county area of central Illinois has shown significant results. The patient distribution of all vehicular-related deaths in this area was studied for the effects of regionalization of patient care for the critically injured. The special emphasis of this report was the effect of the changing character of patient redistribution and the time constants surrounding these changes.

Highway Mortality Rate

The Department of Statistics of the National Safety Council reported a decline of 8% in highway fatalities for the State of Illinois for the first six months of 1972 as compared with the same period of 1971. An increase in highway accidents (8%) and persons injured (9%) was also reported for this period over the entire state. During this same period, the central 15 counties in Region III-A experienced an increase in accidents (27%), an increase in persons sustaining injury (16%), and a decrease in highway deaths (15%). Of particular significance was the steady decline in the percentage of deaths per person injured—a decrease from 2.8% to 2.1% for the study period (pre-program, January-June, 1971; program implementation, July-December, 1971; first six months of full operation, January-June, 1972).

Time of Death

During the implementation and full operation periods of the Illinois Trauma System, there was a significant change in patient survival times. In conjunction with an overall decrease in the number of vehicular deaths, the total number of victims who died at the accident scene dropped from 42 during the first period to 26 in the third period, a decrease of 38%. The number of Dead on Arrival (DOA) at hospital and the number of patients living beyond admission to a designated center increased. Of those admitted to a Trauma Center, the number of those dying within the first hour decreased from 44.4% to 32.1%, with more patients living longer in the hospital while in a better treatment environment.

Summary

Although some controversy still exists as to which is the most important component or subsystem of the Illinois Trauma-EMS System, the Illinois trauma care approach did not attempt to establish *a priori* which subsystem would eventually be considered the most important. Instead,

(Continued on page 256)

Continuing Medical Education and Professional Growth— “*The Physician’s Protection*”

BY THOMAS MEYER, M.B., B.Ch., F.R.C.P./MADISON, WIS.

This is the keynote address for the first Illinois Congress on Continuing Medical Education, April 19, 1973—the first assemblage of physicians from throughout Illinois to consider the problems of CME from the physicians’ viewpoint. Over 100 leaders in Illinois medicine participated. A complete report on the Congress, including this address as well as a summary report of participants’ proposals for the future of Illinois CME, is available upon request to: The Illinois Council on Continuing Medical Education, 360 North Michigan Ave., Chicago, Ill. 60601.

Some sacred cows are now coming under scrutiny, which has not previously been the case in the United States. Those of us in health and education are being called to account for the results of our labors by those who pay the bill. Scholarly manuscripts are no longer sufficient proof of industry in education, and pious proclamation of excellence by those of us practicing in the health professions is no longer sufficient to satisfy public expectations. Like many of you, my colleagues in the Department of Postgraduate Medical Education at the University of Wisconsin and I are at risk in both of these headings—health and education.

The combination of health and education which is the function of an academic medical center finds itself in as serious a dilemma as it has faced in this century. Perhaps I can illuminate three major sources of the dilemma in the hope that some solutions may be forthcoming:

1. There is wide divergence of opinion between the *consumers* of health education, including the public, and the *academic establishment concerning what is appropriate health care.*
2. There seems to be a degree of *distrust between learners*—whether medical students, house staff or practicing physicians—and *teachers* as represented by the medical faculty.
3. There is a growing demand that medical education at all levels be offered in a manner that takes account of the diverse needs of individual learners, their respective backgrounds, learning styles and career goals.

The Perceptions of Health Care

I think that it is important to keep in mind that continuing education is only one avenue toward the goal of improved quality of health care. One cannot take the simplistic view of considering this one facet in a vacuum.

Various groups view the quality of care in different ways and perhaps it would be helpful to identify the way in which these perceptions seem to become manifest.

The Physician

- (a) works as hard and long as he can,
- (b) is making as much money as he can retain and use, *and*
- (c) is generally satisfied with the quality of care he is personally delivering.

The Consumer

- (a) has been led to expect, and consequently is demanding, what he or she defines as a high quality care at reasonable cost which is readily available, *and*
- (b) for the first time is becoming sufficiently organized to make these expectations known.

The Government is

- (a) paying more and more of the health care bill, *and*
- (b) calling on physicians to document the quality of care that is being delivered.

The Educators (defined loosely to include

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PROGRAM DEVELOPMENT

April, 1973

Department of Postgraduate Medical Education

The University of Wisconsin

Current Programming

Telephone/Radio Conferences
On-Campus Conferences
Conference Administration Service
Dial Access Library
Individual Physician Profile
Tape/Slide Sales
Visiting Professor Service
Alumni-Faculty Retreat
Patient Dial Access Library
Single Concept Video Tapes
Medical Student A-V Instruction
Computerized Test Bank
Educational Resource Index
House Staff Objectives
Hospital In-Service Program Review
Therapeutic Criteria Review
Basic Science Symposia
Circuit Teaching Courses
Consumer Health Education Demonstration Project
Psychiatry For Physicians
Pediatric Nurse-Associate Program

In Development

Satellite Research Seminars
Physician-Pharmacist Relationship
National Medical DAIRS
Teaching Slide Bank
International Health Programs

Under Consideration

Postgraduate Preceptorship
Community Pharmacy Study
Microfiche Library
Community Hospital Tape Exchange
Identifying Educational Gatekeepers
Training Secondary Teachers
Dial Access Consultation Service
Motivational Research Study
Community Based Workshops
Teaching Library Service
Practice Management Consultation
New Patterns in Health Care Delivery
Team Inspection/Consultation Service
Service/Teaching Visiting Professor
Faculty Course in Adult Education
In-Depth Program Evaluation

Defunct

Slow-Scan Television
Single Concept Films
Sports Physician Course
County Medical Society Lecture Service
Health Team Workshops

professional associations, voluntary health agencies, medical schools, and hospitals) have come to believe that

- (a) education is good, in and of itself, *and*
- (b) physicians who do not actively pursue a continuing education program (*i.e.* "attend my programs") are bad.

Of all these, perhaps the most realistic view is that of the physician. He probably is practicing high quality medicine in most aspects of his practice. The most unrealistic view may well be that of the Educator. There is some evidence to show that the physician who is staying away from our "education" programs may in fact be

making a wise decision, the return to him and his patients from his attending current continuing education programs may be quite low.

The motivating factors for learning in medicine are difficult to identify, but among them are certainly these:

1. Personal attitudes and value systems
2. Perception of importance of the subject (relevance)
3. Intellectual curiosity
4. Reward or punishment systems
5. Physical and intellectual endurance
6. Fear of not knowing
7. Various others (*e.g.* the patient problem, one-upsmanship).

At least three of these (1, 2 and 4) are in large part regulated by social pressures and attitudes. It seems to me that medical education is unsure how to react to the fact that public expectations in health have changed for the fourth time in this century. Indeed, many of us in medical education have failed to even recognize that a change has occurred. This has led to three major incongruities in health professional education recently listed by Dr. William Stewart.

First is the divergence of public and professional opinion as to the function of health professions. The public sees entitlement to health services and maintenance of health as paramount. Success is measured by the imprecise phrase "quality of life," rather than the measurable prevalence of disease and death. The profession sees the function of the health professionals as further zeroing in on finer and finer targets of disease with greater and more precise skills. Medical education occurs in this tertiary care milieu and the student learns (rightly or wrongly) that the rewards lie in these directions, i.e. the hospitalized patients. This is not the environment of comprehensive or balanced health services.

A second incongruity is linked to the first. Health education centers are supposed to supply manpower to meet the health needs of people. In fact, the education system is principally geared to satisfying the special requirements of running the complex institution that a health science center has become. These requirements are different from those involved in the training of manpower to meet the community's needs. Indeed, the training of manpower to meet the general health requirements of the population is almost a by-product of the health education system as it now exists.

The third incongruity is that it is really no longer possible to define distinctly the boundaries of medical education that takes place in the three or four years when a student is "in medical school." There seem to be multiple reasons for this: the variety of pre-medical curricula in an age of educational experimentation, the continually changing content of residency training, the shift now occurring in the definition of the functions of non-physician health professionals (nurses, physician's assistants). Central to this confusion is the question of what constitutes a "physician" in a time when specialization is the dominant motif. Years ago, society's and the medical school's definition of a medical school's product were essentially similar; this is no longer the case.

Four Eras of Medical Education

I would like to expand on my earlier reference to the fact that we have entered into what seems to me to be the fourth era of medical education since Flexner. These eras may conveniently be labelled:

1. The General Practice Era - 1910-1939
2. The Specialty Practice Era - 1940-1958
3. The Scientific Era - 1959-1968
4. The Community Era - 1969-?

The contribution of Abraham Flexner to modern medical education was the idea of a uniform and systematic grounding in the medical sciences as the foundation for clinical training and practice. This produced a corps of general practitioners who were obviously so superior to their predecessors that medical education changed very little until it became apparent that competence in all areas was impossible. This realization found expression in the rise of specialty board and residency training programs, and the consequent rise in numbers of specialists. The result was the decline in the number of general practitioners from 70% of registered physicians in 1940 to 20% in 1960.

The "scientific era" had its roots in the establishment of the National Institutes of Health, the National Science Foundation and the funding of the National Defense Education Act. All profoundly affected medical schools. Teaching hospitals became preoccupied with complicated and unusual illnesses at the biochemical and histological level. Rewards were generated from elegant scientific dissection of the problem(s) down to the molecular level. Medical care of the patient declined to secondary importance and became the province of eager but inexperienced house staff. Comprehensive care was relegated to the sometimes non-existent outpatient department or to the "L.M.D."

Society's fourth or "community era" was ushered in by Medicare and other programs which produced demands for care that could not be met, along with the realization that many segments of the population were not yet even requesting care. Students applying to medical schools changed along with society. The government became interested in assuring the general availability of adequate health care at a reasonable cost. This has become paramount to the consumer.

These four eras are schematized in the Table I, which presents briefly for each of the four periods of medical education the essences of: the objectives of medical education, curriculum

<p align="center">Table I</p> <p align="center">Medical Education - 1910-197?</p>				
	G.P. 1910-1940	Specialty 1940-1959	Scientific 1959-1968	Community 1968-197?
Objective of Medical Education	General medical education		Research, patient care teaching "scientific"	Faculty Scientific research Teaching, care Admin. Care Scientific research Students Care Social issues
Curriculum	Lock-step. Basic science related to clinical medicine		Lock-step "Pure" basic science "Clinical" basic science Research in electives	Core Extensive electives
Faculty Priorities	(1) Patient care (2) teaching (3) research		(1) Research (2) Consultation (3) teaching	
Student Priorities	Student - Clinician		Student - Scientist	Care - interest in (1) Patients (2) Delivery of care (3) Diverse
Role model	General Practitioner	Specialist	Physician-Scientist 30% patient care 70% research	? Faculty rejected ? Practitioners rejected
Social responsibility of M.D.	Art of medicine- M.D. meets all needs of all patients	Competence in a specialty	Scientist doing research	Community needs Action against social factors that impede health
Continuing Medical Education	Minimal need Minimal effort	Need recognised "Shotgun" therapy	Cannons with buckshot- "advances"	Quality care measurement Needs identification Reinforcement

typical of the era, faculty priorities, student priorities, role models, social responsibility of the physician and continuing medical education patterns. It attempts to provide a comparison of these issues in the four eras. Thus, the objective of medical education in the period from 1910-1959 was to afford the medical student a broadly based background in preparation for almost immediate delivery of health care—after perhaps a year of internship. In the late 1950's and throughout the next decade the emphasis of the objective changed. Research potential became the major thrust, patient care taking a secondary place and the teaching being at a predominantly molecular and biochemical level.

In the current "community era" there seem to be three opinions of the objective of medical education. The faculty is comfortable with the scientific, molecular, research objective and relegates teaching to lesser importance with direct patient care as the least important. Medical school administrators, under duress from outside influences, are encouraging greater importance for patient problem solving as an objective, with scientific research a close second. The students, reflecting public expectations most closely, see patient care as the prime objective of medical

education and social issues which affect health as having very great importance and not receiving sufficient emphasis.

Society, government and medical students have accepted the fact that it is not possible to deliver "Cadillac medical care" to every consumer and simultaneously obtain widespread adequate care at reasonable cost. Academia has not accepted this. From this, then, stems the cry for "relevance" and the fact that the student's value system does not demand understanding of the minute details of structure and function at the microscopic and molecular levels. Rather, he is interested in the "big picture" and wider issues and is, I believe, prepared to sacrifice the individual for the good of the community. All this is anathema to the scientist, the purist and those trained to preserve life at almost any cost. This is a deep-seated cause of conflict.

We see this conflict most sharply when we look at medical student expectations and the contradiction between their primary interests and the reality of contemporary medical education that is largely the product of the scientific era. Thus, we have students whose thinking is consonant with those of the community era

being exposed to medical education that evolved during a previous era. This leads to the student leaving medical school in a sense of frustration.

Implications for continuing medical education are equally important. The former student, frustrated when he left medical school, discovers that his frustration is carried over into his new life-career. What ought to be a source of satisfaction—performing well a set of complex tasks for which he has been highly trained—becomes, instead, a source of self-doubt and anxiety because he is asked to perform those functions which were not within his training in medical school. In turn the medical faculty responds by insisting that the difficulty lies outside medical school—perhaps the government's failure to fund adequately, or the student's failure to learn what biomedical scientist/faculty members feel he should have learned.

It is not surprising, then, that many physicians prefer sources other than medical schools for continuing education, or that many faculty members should do so poorly in helping the physicians to practice continuing growth professionally.

At another level there is an even greater problem. The bulk of practicing physicians today are those trained in the scientific era. They now discover that the habits so carefully inculcated during their years as medical students no longer bring satisfaction. On the contrary, they often bring charges of insensitivity to social needs from a variety of social/political groups, government and individual patients.

This is, of course, one of the reasons we have gathered to identify for ourselves, on behalf of all Illinois physicians, goals for continuing education that others have not formulated—goals appropriate to one's individual development and to the demands of contemporary society. I was asked to set the stage for your thinking by outlining briefly the scope of the program that has evolved in Wisconsin. This is based on the belief that physicians learn the same ways as non-physicians—in different ways, at different times of the day and night, in different environments and for different reasons. If we are to serve this variety of learners then we must develop the means to serve their individual needs. This then leads to the wide variety of offerings which are available.

I hope that you will not confine your thinking to the traditional journal, conference type of continuing education. Improved care of patients is our goal, the means is continuing education—but education need not be dull, irrelevant or stereotyped.

Summary

I have attempted in a short time to stimulate a thoughtful analysis of the problems of continuing medical education, which are the problems of medical education. It is my hope that the identification of some of the dilemmas and the incongruities we all face will assist in the identification of some possible solutions. ◀

Acknowledgement

The author attributes much of the thought in this article from a paper written by Daniel H. Funkenstein, M.D., in the book *Psychosocial Aspects of Medical Training*, edited by Coombs and Vincent (Charles C. Thomas, Publisher).

ICCME OFFERS "Your Personal Learning Plan"

A 32-page pamphlet, "Your Personal Learning Plan," has recently been developed by the Illinois Council on Continuing Medical Education (ICCME), to assist the individual physician plan continuing medical education in a systematic fashion. A unique feature of this handbook is a special set of worksheets—similar in format to the patient medical record—to help the physicians think through and record personal learning plans. Any Illinois physician (M.D. or D.O.) may have a copy FREE upon request by writing "Personal Learning Plan" on your prescription form and mailing to: ICCME, 360 North Michigan Ave., Chicago, 60601. The cost is \$1.00 per copy for others.

Watch For the ISMS GUIDE TO CONTINUING MEDICAL EDUCATION feature beginning in the November *Illinois Medical Journal*

Febrile Reaction of Gaucher's Disease

By ARTHUR A. BILLINGS, M.D., MELVIN POST, M.D., and CHARLES M. SHAPIRO, M.D., F.A.C.P./CHICAGO

Febrile episodes during the course of Gaucher's disease (GD) are well documented, but the relationship between fever and the basic disease has not been established.¹⁻³

We have had the opportunity to follow a patient with GD of 41 years duration. Her clinical course provides some insight into the etiology of fever in this entity.

Case Report

B. B., female, age 5, was first admitted to Michael Reese Hospital in 1929 because of pallor, progressive abdominal enlargement, and epistaxis. The past history and family history were unremarkable.

Physical examination at that time revealed moderate cervical, axillary and inguinal lymphadenopathy. The spleen extended down to the left iliac crest. The liver was palpable four centimeters below the right costal margin.

There was a pancytopenia: the hemoglobin was 50% (Sahli); white blood count 3,050/mm.³ platelets, 10,000/mm.³ Typical Gaucher cells were found in the splenic aspirate. Splenectomy was performed with relief of the hypersplenic syndrome.



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Over the ensuing 11 years the patient was hospitalized seven times. Four of these admissions were precipitated by bone pain, and associated with febrile periods that lasted 10 to 14 days. Because of progressive X-ray changes in the skeletal system, bone biopsies for culture were performed during two hospitalizations. In each instance, the cultures were negative for bacterial growth.⁴ Gaucher cells were noted in the marrow (Fig. 1).

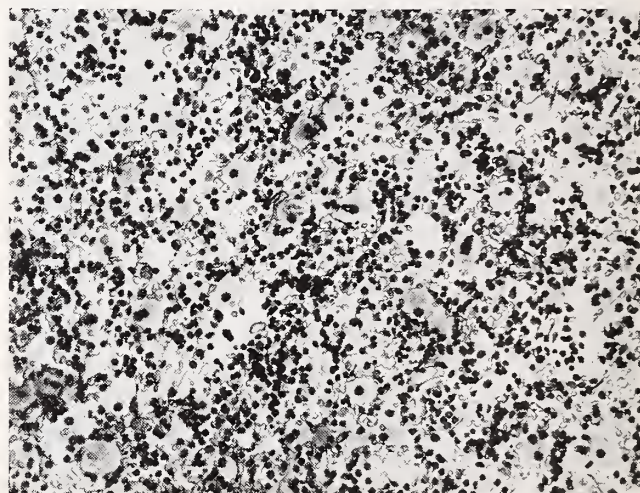


Fig. 1 Bone marrow showing marked infiltration with Gaucher cells.

In 1945, at age 21, the patient had a normal pregnancy and was delivered of a healthy male child. In 1964, when she was 40 years old, severe menorrhagia precipitated another hospital admission. At that time, physical examination showed an enlarged liver extending 11 centimeters below the right costal margin. In addition, she had large uterine leiomyomatoma. Normal proliferative endometrial tissue was obtained on a diagnostic dilatation and curettage.

She remained afebrile throughout her hospital stay.

During the following two years, the patient had two operative procedures: a rectal biopsy as part of the evaluation of intractable diarrhea of four months duration and a segmental resection of a benign breast mass. Neither of these procedures elicited a febrile reaction.

On March 20, 1967, the patient fell and sustained a comminuted fracture of the left humerus (Fig. 2). She was placed in a hanging long arm plaster cast, but had to be hospitalized three days later when she developed fever with temperature elevations to 103°F. Physical examination was normal except for the hepatomegaly and uterine leiomyomata previously noted.



Fig. 2 Comminuted pathologic fracture of left humerus; areas in the fracture site show lysed bone.

The hemoglobin was 10gm/100 ml.; reticulocytes, 100,000/mm³; white blood cell count, 8,300/mm³; platelets numbered 500,000. The peripheral blood films showed a relative lymphocytosis and nucleated red blood cells, Howell-Jolly bodies and many target cells. Red blood cell abnormalities were attributed to the splenectomy 39 years previously, and were present in the intervening years.⁵

Liver function tests, including bilirubin, cephalin-cholesterol flocculation, thymol turbidity, serum glutamic oxalacetic transaminase (SGOT),

serum glutamic pyruvic transaminase (SGPT), lactic acid dehydrogenase (LDH) and alkaline phosphatase determinations, were repeatedly normal. Urinalyses were normal. Repetitive cultures of blood, urine and stool showed no growth. Common bacterial agglutination titers were negative. Serum protein electrophoresis and assays for immunoglobulins by immunodiffusion techniques were normal.⁶ X-rays of the chest, kidney and gastrointestinal tract were normal. However, the skeletal system showed extensive changes as seen in GD (Fig. 3a,b).

The persistence of temperature elevations led to therapeutic trials with various antibiotics, prednisone and antipyretic agents without effecting defervescence. Heparin therapy, 300 mg daily, was instituted because of the possibility of a septic pelvic thrombophlebitis. This, too, was unrewarding. On the 16th hospital day, a biopsy of the fracture site was performed for bacteriologic studies. These cultures were negative.

The patient tolerated her prolonged febrile state quite well. Vital signs remained stable. Anorexia was minimal and she lost no weight. She was discharged with a temperature of 103°F., after 67 days, on no therapy. Over the following three weeks good callus formation developed at the fracture site, and concomitantly, the fever lysed.

Four months later, September 12, 1967, the patient was readmitted with a sudden onset of severe low back pain, radiating into the posterior aspect of the lower extremities. Evidence of bilateral sciatic nerve root irritation was found on physical examination. On the seventh hospital day, her febrile state returned (Fig. 4).

Extensive laboratory tests showed no abnormalities. Additional blood studies for acid phosphatase, complement, thyroid function, and urinalyses for 17-ketosteroids, total corticoids, catecholamines and etiocholanolone all were normal. X-rays of the lumbosacral spine were unchanged. There was no evidence of acute fracture.

She was treated with analgesics and pelvic traction. Antibiotics and adrenal cortico-steroid therapy were ineffective in lowering her temperature. Six-mercaptopurine, 100mg daily, was added to the patient's therapy on the 43rd day. Within ten days, her temperature had returned to normal levels, and 6-mercaptopurine was discontinued.

On the 58th hospital day, the patient had a dilatation and curettage for severe vaginal bleeding. Upon awakening from the anesthesia, she



Fig. 3a, b Antero-posterior and lateral X-rays of the left knee show degenerative arthritic changes in the joint and multiple large loose bodies. Note the large coalesced cystic areas in the femur and tibia.

complained of back pain and within eight hours her fever returned. Reinstitution of 6-mercaptopurine, 200 mg daily, had no effect. On the 74th hospital day, azathioprine, 100 mg daily, was added to what was clearly ineffective corticosteroid treatment. Within three days her peak temperature began to fall, and reached a nadir of 99.2°F. after ten days. At this time an arthroscopy of her left knee was performed in order to remove several loose osteocartilaginous bodies that had suddenly caused severe knee pain associated with synovitis and recurring locking. Marked temperature elevation again appeared. On the 108th hospital day, cyclophosphamide therapy, 100 mg daily, was initiated. This was maintained as the fever gradually lysed and the patient was discharged from the hospital.

In the following 18 months she had a viral gastro-enteritis and a bacterial pharyngitis, with febrile responses appropriate both in degree and duration.

Reoccurrence of severe lower back pain led to re-hospitalization on May 1, 1969 (Fig. 5). Physical examination confirmed the presence of left sciatic nerve root irritation. X-ray studies were unchanged. Laboratory tests again were voluminous and unrewarding.

The patient was treated conservatively with bed rest, pelvic traction, various antipyretics and narcotics including diazepam, meperidine hydrochloride, acetaminophen, indomethacin, oxyphenbutazone, and aspirin. When the temperature rose above 105°F., she was placed on a cooling mattress. The skeletal pain increased with the heightened fever response. Emotional lability was apparent with temperature above 106°F. Vital signs remained exceedingly stable, with only occasional pulse rates over 110 per minute.

Trials with various immunosuppressive drugs were ineffective in lowering her temperature. On the 77th hospital day, 20 days after the onset and persistence of inordinately high temperatures, over 107°F., reserpine therapy, 0.2 mg daily, was started. Within 36 hours there was defervescence that was progressive and continuous. The reserpine therapy was discontinued three weeks after discharge from the hospital.

During the past two years, she has experienced four separate episodes of bone pain associated with temperature elevations. Two of these were successfully treated with reserpine, defervescence

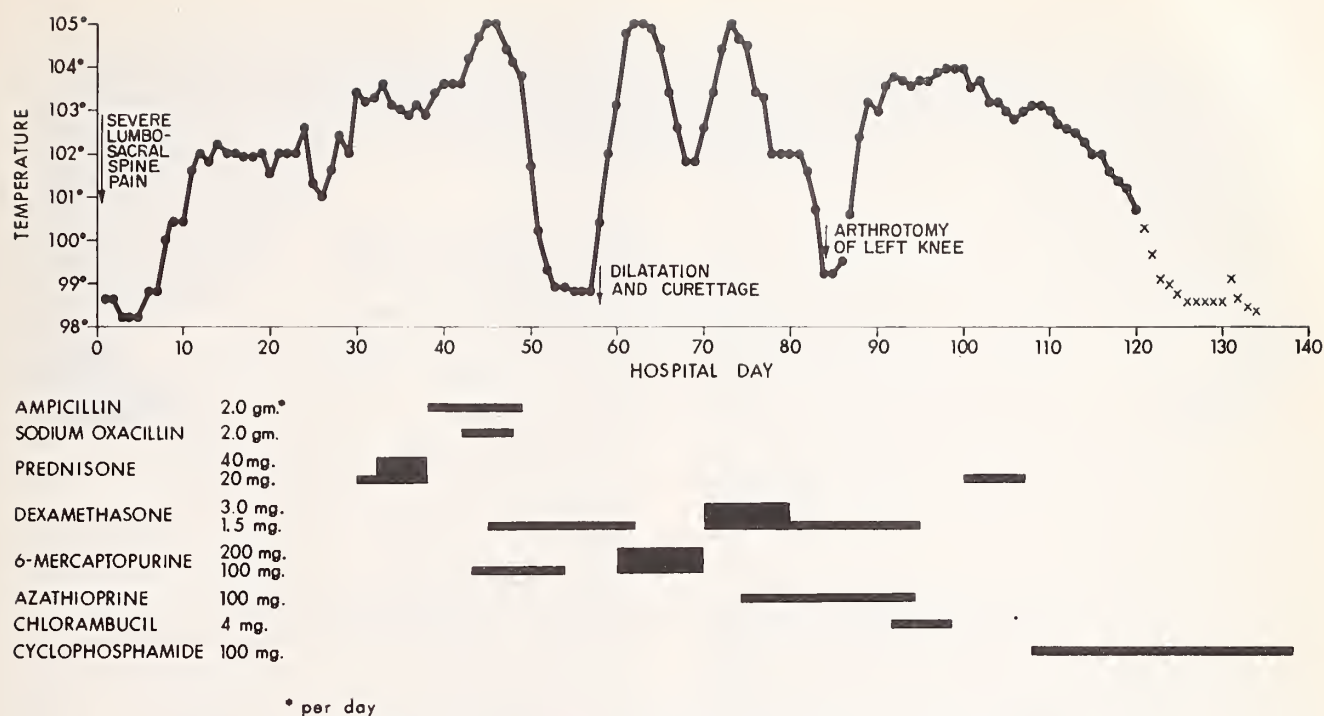


Fig. 4 Hospital course following September, 1967, admission for lumbo-sacral pain. X: out-patient peak temperatures.

occurring within seven days. In the last two episodes, reserpine lowered the fever by several degrees, but normal temperature was obtained only when bone pain in the vertebral column ceased.

Discussion

Gaucher disease (GD) is an inherited metabolic disease characterized by the accumulation of sphingolipid in reticuloendothelial cells. The basic defect is a deficiency of an enzyme required for the normal catabolism of glucocerebroside, the sphingolipid found in GD.⁷ There appears to be no increased production of the glucocerebroside.⁸

The clinical manifestations of GD reflects the degree and site of reticuloendothelial cell accumulation of the cerebroside. The more catastrophic clinical course in infantile forms of GD may represent a more profound lack of the degrading enzyme.⁹

Although febrile episodes are not uncommon in patients with GD,¹⁻⁴ the duration and magnitude of temperature elevation found in our patient is most unusual. Infection does not seem to play an etiologic role in these episodes, and the literature is replete with reports of needless bone biopsies.³ Rarely, an infective agent may be found.¹⁰ Our patient has had three sterile bone biopsies and extensive bacteriologic studies have been uniformly negative.

The possibility that the febrile episodes in

GD reflected vascular occlusion with bone infarction was postulated by Amstutz et al,³ who noted clinical similarity to patients with sickle cell disease. However, the degree and magnitude of the febrile state in GD far exceeds any found in uncomplicated sickle cell bone disease. The ineffectiveness of common antipyretic drugs in the febrile episodes of GD also suggests a different pathogenesis. Furthermore, biopsy of the fracture site failed to reveal changes of bone infarction.

Other common causes of fever could not be documented in our patient. Factitious fever was quickly eliminated by careful monitoring of the temperature-taking procedures. Her normal response to ordinary viral and bacterial infections makes an abnormality in the hypothalamic temperature regulating centers unlikely, and simple tissue injury also seems unlikely as a precipitating cause of her febrile response, in view of her tolerance to rectal and breast biopsy.

Immunologic abnormalities have been reported in patients with GD, and these may present as a monoclonal dysproteinemia.¹¹ What form the antigenic stimulus takes in such patients is not known, as Joffe et al¹³ were unable to demonstrate antigenicity for glucocerebroside. Attempts to demonstrate abnormalities in our patient's immune system have not been successful. Serum concentrations of immunoglobulins were normal. Tests of the patient's sera for complement-fixing antibodies against glucocere-

broside were negative.* Studies for precipitating antibodies to glucocerebroside utilizing immunodiffusion techniques have not been successful to date.†

The association of bone pain and fever suggests that the febrile reaction in GD represents an allergic response to the liberation of glucocerebroside, or one of its metabolites, from a broken bone. In our patient, temperature elevation followed bone pain and never preceded it. The extensive pathologic changes due to GD precluded definite confirmation of a new fracture in every episode. The cessation of fever only after healing of the humeral fracture is compatible with this hypothesis. During the last two hospitalizations, regression of fever, regardless of drug therapy was associated with progressive decline in bone pain.

The assumption that the patients' fever represented an expression of an allergic reaction, resulted in trials with immunosuppressive drugs. The inconstancy and variable effect of the drugs employed is difficult to explain. It seems unlikely that their salutary effect on temperature reduction was always temporally related to a phase of healing fracture, with decreased liberation of the postulated lipid pyrogen. Even more puzzling was the inability of those drugs that were associated with temperature reduction to exert a similar effect upon repeated trials.

*Kindly performed by Dr. Maurice Rapport.
†Glucocerebroside provided by Dr. Roscoe Brady

During the patient's last hospitalization, when her temperature would not respond to any modality of treatment, it was decided to attempt to alter the response of her hypothalamic temperature regulating centers. According to the work of Feldberg and Myers, thermo-regulation is accomplished by release of various monoamines in the hypothalamus.¹³ Serotonin causes a rise and norepinephrine a fall in temperature in monkeys.¹⁴

Reserpine is known to deplete brain and peripheral tissues of many monoamines, including serotonin and norepinephrine.^{15,16} This, coupled with its ability to lower temperature of patients with hyperthermia of thyrotoxicosis¹⁷ led us to try reserpine on our patient. Initially, on three occasions, fever associated with bone pain resolved on reserpine therapy. In subsequent febrile episodes, reserpine lowered but did not return the temperature to normal levels.

Our patient had no clinical evidence of adrenergic excess, and urinary studies for catecholamines were normal. Thus, the means whereby reserpine effected temperature reduction remains unanswered.

Summary

A 46-year-old woman with Gaucher's disease of 41 years duration developed profound temperature elevations after bone injury. It is suggested (Continued on page 252)

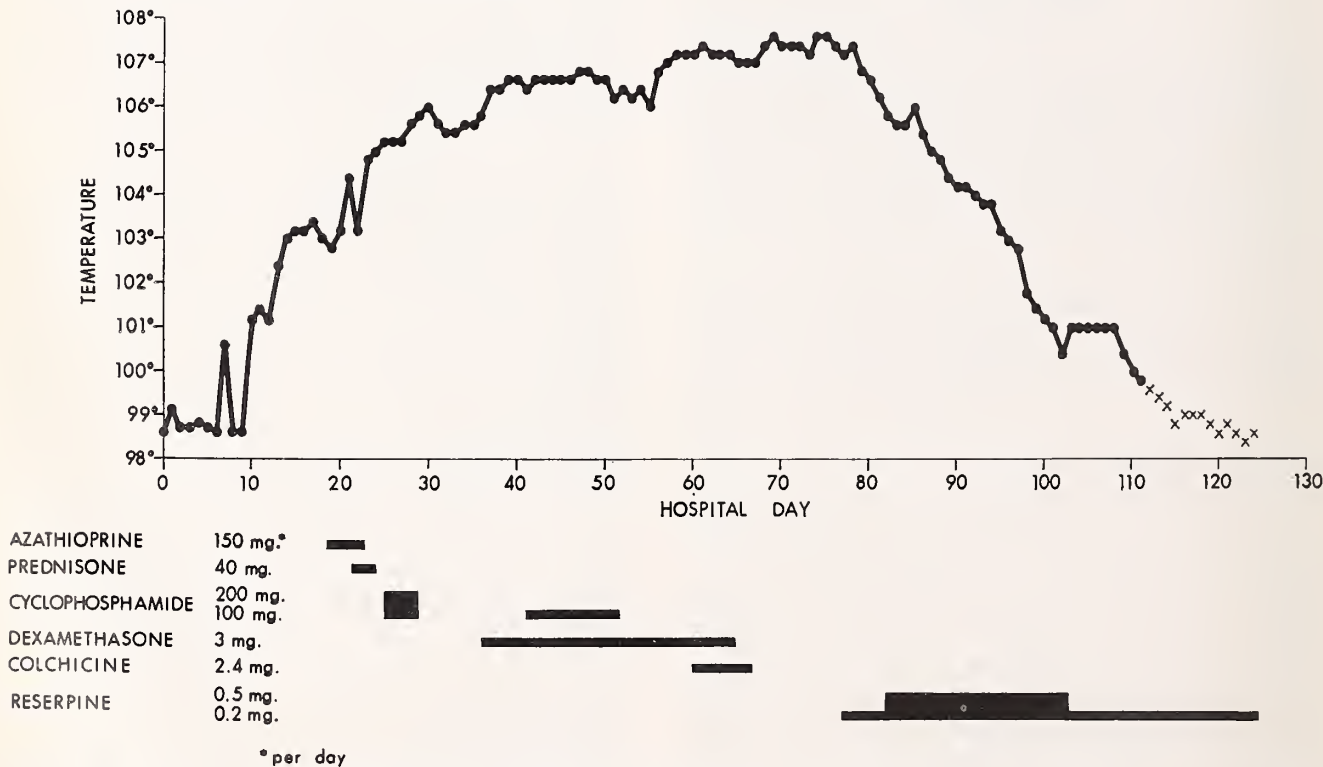
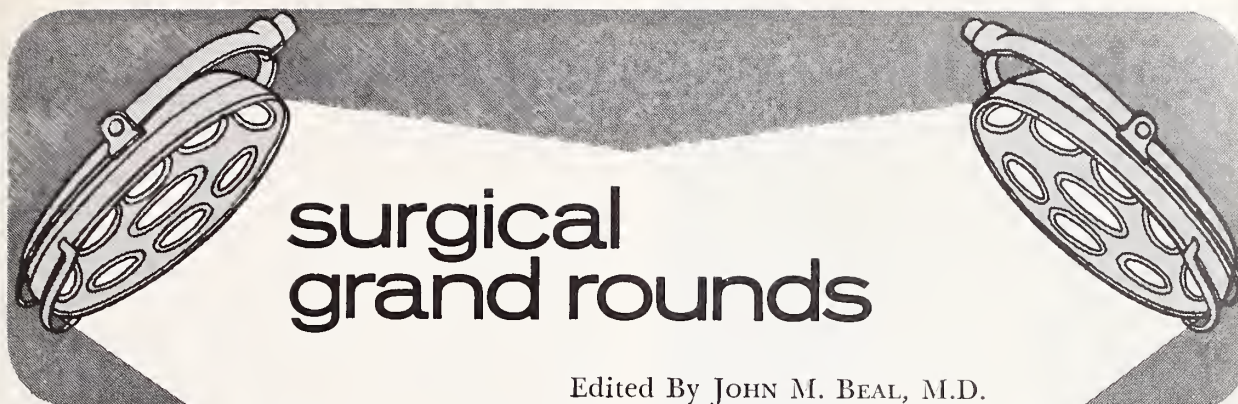


Fig. 5 Hospital course following May, 1969, admission for lumbo-sacral pain. X: out-patient peak temperatures.



Edited By JOHN M. BEAL, M.D.

Gunshot Wound of the Back

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Passavant Pavilion, Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 30, 1973.

Dr. Glen Glista: A 42-year-old male entered Northwestern Memorial Hospital approximately ten minutes after sustaining a gunshot wound to the back. His complaints at the time of arrival were pain at the site of the wound and inability to move his legs after the injury. His review of systems and past medical history were unremarkable. At the time of physical examination, he appeared alert and oriented. His extremities were cool and dry. He had an obvious inability to move his lower extremities. There was a puncture wound (wound of entrance) just to right of the midline, adjacent to the first lumbar vertebra. Pulse was 100, blood pressure 100/70, respirations 24. Chest was clear to percussion and auscultation. Heart had a normal sinus rhythm without murmurs. Abdomen did not appear to be distended, was soft to palpation and without masses or organomegaly. Bowel sounds were present. Rectal examination disclosed a patulous anal sphincter. Normal stool without blood was present. Neurological examination revealed absence of spontaneous movement in the right lower extremity and minimal movement of the quadriceps muscles in the left leg. He was anesthetic in the entire right lower extremity at L-1 level, and at L-3 level on the left. Blood was drawn for typing and cross-

matching, and intravenous route with central venous pressure was established. The hemogram was normal on admission.

A nasogastric tube was passed which yielded several small strands of clotted blood. After irrigation with normal saline solution, the rectum was clear. A urethral catheter was inserted which yielded 150 cc of clear yellow urine. Urinalysis revealed 20 RBC/high power field. It was felt that the patient's cardiovascular system was stable and he was then taken for several diagnostic X-rays.

Dr. Earl Nudelman: The initial supine and transthoracic chest radiographs show a bullet posterior in location. (Figure 1). Films of the abdomen show bullet fragments to the right of the upper lumbar segments and in the projection field of the spinal canal. (Figure 2). Following intravenous injection of contrast material, there is prompt symmetrical excretion in fair concentration. The kidneys are not displaced. The cystogram is within normal limits. There is partial opacification over the apex of the left lung due to effusion and/or tissue damage due to passage of the bullet. There is no evidence of a pneumothorax. No rib fractures are demonstrated.

Dr. Glen Glista: Other pertinent laboratory



Figure 1. Chest X-ray demonstrates bullet in the left upper chest with partial opacification of the left lung field.

data were a hematocrit of 37, a white blood count of 10,200 and normal serum electrolyte concentrations. After the X-rays were reviewed, he was taken to the operating room. A chest tube was inserted, using local anesthesia, in the left mid-axillary line through the 5th intercostal space. General anesthesia was instituted and a laparotomy performed. When the abdomen was opened, approximately a liter of blood was found. Systemic examination disclosed the tip of the spleen to be lacerated, and a splenectomy was performed. After the spleen was removed, blood continued to pool in the left upper quadrant. A hole, approximately 2 centimeters in diameter was found in the left hemidiaphragm. A suction catheter was passed gently into the left pleural cavity and approximately 200 cc of blood was withdrawn from the left hemi-thorax. Simple closure of the diaphragmatic laceration was performed. Then the abdomen incision was closed.

The patient was placed prone on the operating table and had a laminectomy performed from T-12 to the L-3 level. Some bone fragmentation was encountered, but the dura was intact. However, when the dura was opened, contusion of the conus and several lacerated fibers of the cauda equina was found. The wound was debrided and the laminectomy wound was closed.

He was free of post operative complications and his chest tube was removed on the fifth post operative day.

Dr. Alex McGinnis: This case represents the problems presented by a patient who had several regions of the body injured simultaneously. It became apparent fairly early in the course of this patient's evaluation that there were three regions involved. There was the chest injury, the possible intra-abdominal injury, and the spinal cord injury. The cardiovascular and respiratory systems must receive top priority in the multiply injured patient. This patient's cardiovascular system was stabilized by rapid infusion of intravenous fluid and the respiratory system was stabilized by placement of a closed thoracostomy water seal drainage tube. Attention was then turned to determine whether there was intra-abdominal injury. The chest injury was managed by Dr. Vanecko; the abdominal injury was managed by Dr. Govostis and the spinal cord injury was managed by Dr. Siqueira.

There is general agreement that gunshot wounds of the abdomen require automatic laparotomy. It is important to remember that there are four sides to the abdomen and the wound in this patient's back represented merely a wound of the posterior aspect of the abdomen. The mere existence of the wound was sufficient justification to proceed with a laparotomy. Two other features of the case provide further justification for performing the laparotomy. First of all, since the site of entrance of the bullet was in the back and X-rays showed that the bullet came to a stop up in the chest, it could be assumed that the bullet did pass through the peritoneal cavity to produce some kind of intra-abdominal injury. Secondly, although the patient did not have signs of peritoneal irritation when he was first evaluated in the Emergency Room, by the time he was in the operating room, he had guarding and mild rebound tenderness.

It was not always so that gunshot wounds of the abdomen were automatically explored. Prior to 1882, surgical teaching throughout the world was that gunshot wounds of the abdomen should not be explored.¹ During the Civil War, a gunshot wound of the abdomen nearly always led to death. The soldiers upon whom laparotomy was performed all died promptly. The only survivors were among those who were treated conservatively. In the 1880's, the first somewhat accepted recommendation for performing laparotomy automatically for gunshot wounds of the abdomen was made by a gynecologist in New York, Dr. Sims. The first attempt to follow this recom-

In World War I, the mortality rate was still 50% following laparotomy for gunshot wounds of the abdomen, but by World War II, the mortality rate was lowered to 25%. In the case that was presented today, the intra-abdominal injury was certainly not apparent, but the man did indeed have a wound of his spleen and a hole in his diaphragm and the automatic laparotomy certainly did pay off. The chest injury and the spinal cord will be discussed by Dr. Vanecko and Dr. Siqueira, respectively.

Dr. Robert Vanecko: I think the chest X-ray, which shows a haziness to the entire left hemithorax, is a clue to the fact that he had an injury to the left lung with a hemi-thorax. Exploration of his abdomen necessitated the use of general anesthesia with the use of positive pressure breathing. It is mandatory in this situation to stabilize the injured hemi-thorax. The most efficient way of doing this is with an intercostal chest tube and water seal drainage. It may be misleading to try to predict the course of a bullet by the location of the wound of entrance and its final resting place. However, in most civilian injuries with low velocity missiles, the bullet generally follows a straight line. On the plain films of the abdomen, the metallic fragments indicate that, at least across the spinal column and into the first part of the abdomen, the bullet was traveling in a straight line, and from this course it would be fairly safe to assume that it would avoid the mediastinum and the heart. Also, the fact that his cardiovascular system was stabilized led us to believe that there was no serious injury to the heart. I think that the important thing is to have adequate drainage of the chest to prevent tension pneumothorax, remove blood from the pleura and keep the lung fully expanded if the abdomen is to be explored. As to the repair of the diaphragm, during the presentation, it was casually mentioned that there was still a little bleeding around the diaphragm, so they looked a bit more and found a hole in the diaphragm. I'm sure this was not exactly the case. I think that they were well aware that it is important to find this hole and repair it. When bullets pierce the diaphragm, especially through its muscular portion, the hole may not be readily apparent. It must be looked for and repaired or you risk the chance of a subsequent traumatic diaphragmatic hernia. This may not occur for several months to years after the initial injury. This is particularly a danger with stab wounds of the chest, especially of the left lower chest. With the location of this injury, if the chest injury were more severe, possibly a severe laceration

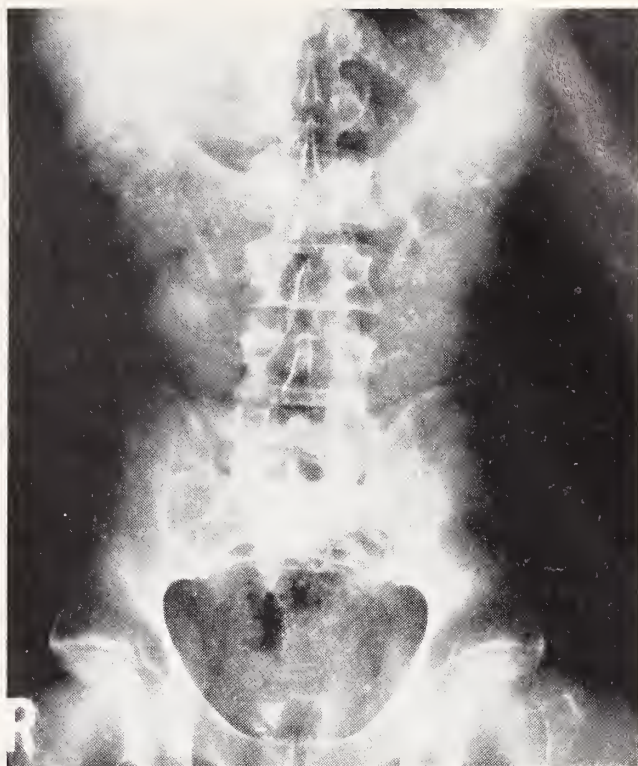


Figure 2. Abdomen films showed bullet fragments at the level of L-1 and L-2. The ureters are visible after intravenous pyelography.

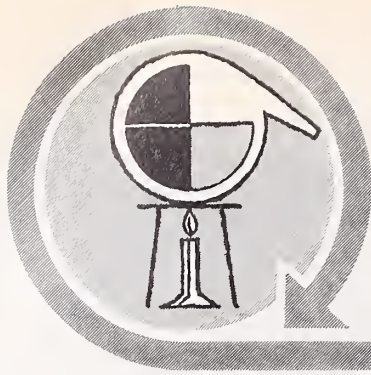
of the lung with uncontrolled bleeding or air leak, this man could be explored through the chest. After the chest injury is controlled, the diaphragm could be opened and the abdominal injury, in this instance, could probably be handled through the chest without too much difficulty. In this particular case, the chest was well stabilized and it was not necessary to enter the chest.

Dr. Edir B. Siqueira: The radiological studies indicate clearly that the bullet entered the spinal canal at the level of L-2 and L-1. There are fragments of the bullet and of bone within the spinal canal at these levels.

Regarding the priority for treatment, there is no question that the central nervous system was secondary in this case. There are several reasons for this reasoning. One of them is the overall poor prognosis for gunshot wounds of the spinal cord. Another reason was the evidence of intra-abdominal bleeding, which could have caused severe blood loss. Thirdly, there is no evidence of any progression or deterioration of the neurological deficits.

Regarding the indications for surgery in the spinal canal in this case, there are at least two major indications: one is that the lesion was at least partially in the cauda equina. The lesions

(Continued on page 263)



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Combination Products: Drugs consisting of two or more active ingredients.

Duplicate Single Drugs: Drugs marketed by more than one manufacturer.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

CLEOCIN PHOSPHATE	Antibiotic	R
Manufacturer:	The Upjohn Company	
Nonproprietary Name:	Clindamycin Phosphate	
Indications:	Infections caused by susceptible strains of streptococci, pneumococci, staphylococci, and anaerobic bacteria.	
Contraindications:	Sensitivity to clindamycin phosphate	
Precautions:	Follow package insert.	
Dosage:	i.m. or i.v. 600 mg. to 2,700 mg./day in 2, 3 or 4 equal doses, depending on severity of infection.	
Supplied:	Ampules 2, 4 and 6 cc.; cc/150 mg. equivalent to clindamycin base.	
AARANE		
Manufacturer:	Syntex Laboratories, Inc.	
Nonproprietary Name:	Cromolyn sodium	
Indications:	Management of severe perennial bronchial asthma; not suitable for treatment of acute attacks.	
Contraindications:	Sensitivity to cromolyn sodium	
Precautions:	Cough and/or bronchospasm has been observed occasionally.	
Dosage:	Contents of one capsule inhaled q.i.d.	
Supplied:	Capsules 20 mg. with turbo-inhaler	
SANOREX	Antiobesity Drug	R
Manufacturer:	Sandoz Pharmaceuticals	
Nonproprietary Name:	Mazindol	
Indications:	Short-term management of exogenous obesity and as adjunct in regimen of weight reduction.	
Contraindications:	Glaucoma and sensitivity to mazindol	
Precautions:	Caution is needed in diabetic and hypertensive patients.	
Dosage:	1 mg. t.i.d., or 2 mg. as single dose one hour before lunch.	
Supplied:	Tablets 2 mg., scored	

DUPLICATE SINGLE DRUG

PFIZER-E	Antibiotic	R
Manufacturer:	Pfizer Laboratories Div., Pfizer, Inc.	
Nonproprietary Name:	Erythromycin Stearate	
Indications:	Streptococcal and other infections caused by susceptible organisms.	
Contraindications:	Sensitivity to erythromycin	
Precautions:	Patients with impaired hepatic function.	
Dosage:	250 mg. every six hours, adjust to patient's response.	
Supplied:	Tablets equivalent to 250 mg. erythromycin.	
SANTYL Ointment	Enzyme	R
Distributor:	Knoll Pharmaceutical Company	
Nonproprietary Name:	Collagenase	
Indications:	To debride dermal ulcers and severely burned areas.	
Precautions:	Do not use with detergents, hexachlorophene and heavy metals used in some antiseptics.	
Dosage:	Apply once daily.	
Supplied:	Ointment, 250 units collagenase per gram of white petrolatum	
POLYCILLIN - PRB	Antibiotic Combination	R
Manufacturer:	Bristol Laboratories	
Composition:	Ampicillin trihydrate 3.5 gm. Probenecid 1.0 gm.	
Indications:	Uncomplicated gonorrhea	
Contraindications:	Hypersensitivity to any penicillin or probenecid.	
Precautions:	Follow-up cultures 7 to 14 days after single dose.	
Dosage:	Single dose of both ingredients	
Supplied:	Oral suspension, single-dose bottle	

NEW DOSAGE FORMS

NegGram SUSPENSION	Urinary Antiinfective	R
Manufacturer:	Winthrop Laboratories	
Nonproprietary Name:	Nalidixic acid	
Indications:	Urinary Tract infections caused by sensitive organisms.	
Precautions:	Renal and liver function tests to be made on prolonged therapy.	
Dosage:	See package insert	
Supplied:	Bottles 16 ozs., 250 mg./5 cc.	
POTASSIUM CHLORIDE POWDER	Potassium Replacement	R
Manufacturer:	Philips Roxane Laboratories, Inc.	
Nonproprietary Name:	Potassium Chloride	
Indications:	Potassium deficiency states	
Dosage:	As required	
Supplied:	Packets 4 gm., 20 mEq. potassium and 20 mEq. chloride.	



Spasm reactor?

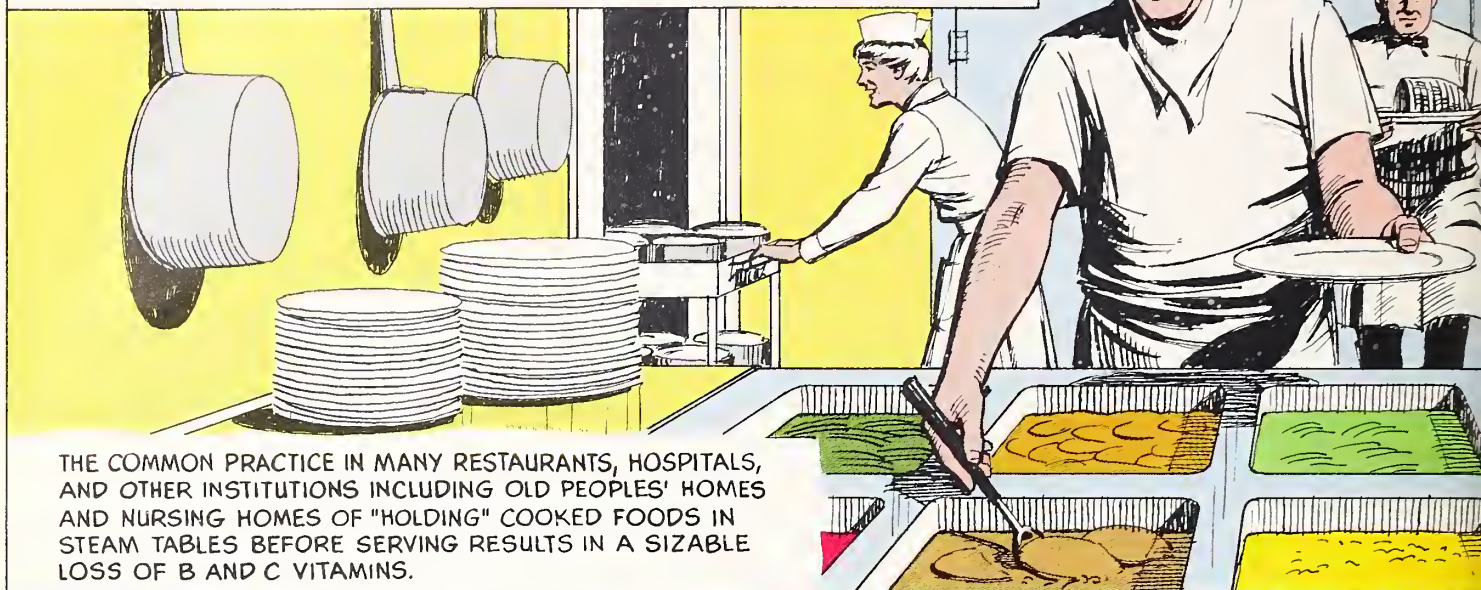
Donnatal!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
tyrosine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
tyrosine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
tyrosine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	($\frac{1}{4}$ gr.) 16.2 mg.	($\frac{1}{2}$ gr.) 32.4 mg.	($\frac{3}{4}$ gr.) 48.6 mg.
Warning: may be habit forming			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

A-H-ROBINS A. H. Robins Company, Richmond, Virginia 23220

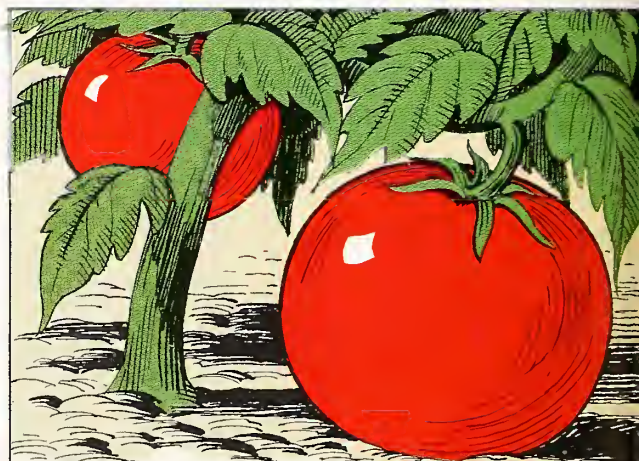
The **ALLBEE® with C** SCRAPBOOK of Vitamin Facts & Fallacies



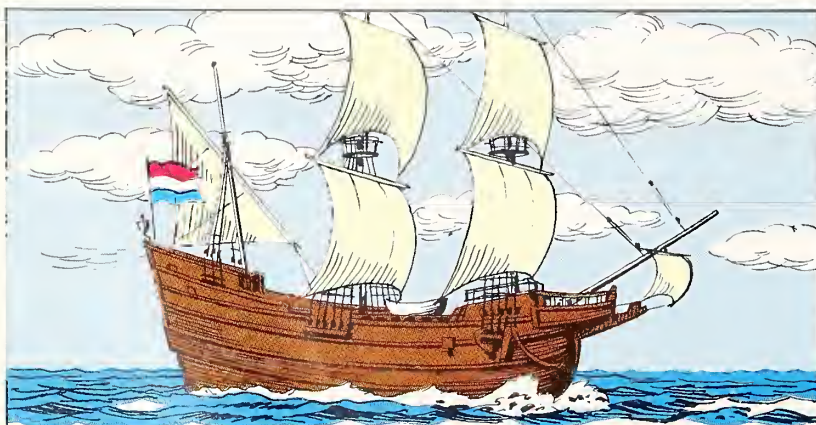
THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZEABLE LOSS OF B AND C VITAMINS.



DURING THE CIVIL WAR 30,714 CASES OF SCURVY WERE REPORTED, AND 383 DEATHS WERE ATTRIBUTED DIRECTLY TO THE DISEASE.



THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.



RONSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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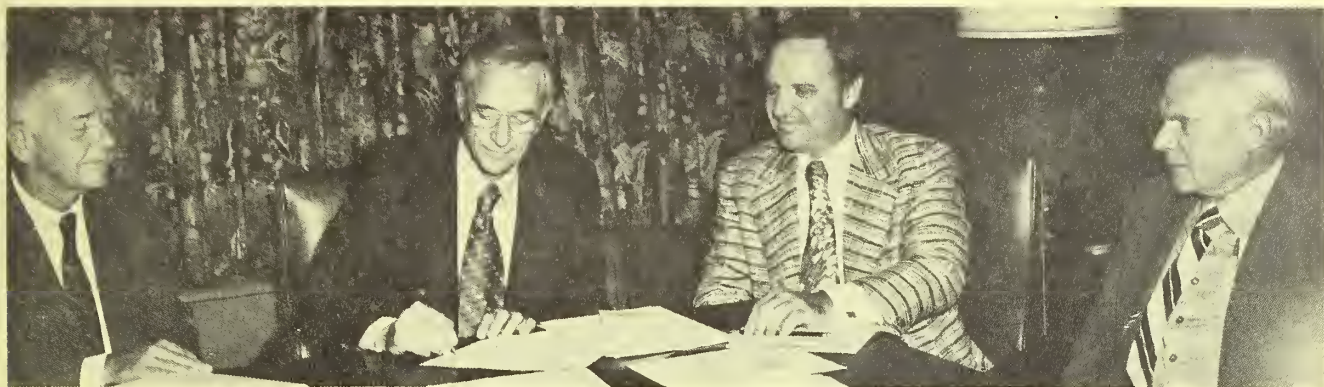


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A.H. ROBINS

Doctor's News

Memorial Hospital First to Receive ISMS Accreditation



Herschel Browns, M.D., Chairman of the ISMS Accreditation Committee (second from the left) signs the approval of the continuing education program at Memorial Hospital of DuPage County in Elmhurst. Memorial Hospital is the first hospital in Illinois to receive such accreditation. ISMS is responsible for accrediting Illinois programs in continuing medical education and the AMA approves of the national programs.

Pictured with Dr. Browns are (from left to right): Rutledge Howard, M.D., AMA Department of Continuing Medical Education; Ross Hutchinson, M.D., member of the ISMS Accreditation Committee and John Huss, M.D., Director of Medical Education at Memorial Hospital.

SOUTHERN ILLINOIS MEDICAL ASSOCIATION TO HOST MEETING—The 99th meeting of the Southern Illinois Medical Association will be held November 8, 1973, in Belleville. Subjects to be discussed at the meeting include renal diseases in pregnancy and diabetes and thyroid dysfunction in gestation.

HOSPITALS FORM FAB³/CME—A Continuing Medical Education program known as FAB³/CME has been initiated by Forkosh, American, Belmont, Bethesda and Bethany Methodist Hospitals in Chicago. The program committee, under the chairmanship of Dr. Philip Thorek, consists of the administrator of each hospital, the chairman of each hospital's continuing medical education committee and a special representative of the Department of Family Practice.

DAVID M. KINZER LEAVES IHA—The executive vice president of the Illinois Hospital Association, David M. Kinzer, has resigned to become President of the Massachusetts Hospital Association.

PHYSICIANS IN THE NEWS—Gerald S. Loros, M.D., has been appointed Chairman of the Section of Orthopedic Surgery at the University of Chicago. New officers of the Chicago Gynecological Society are: William R. Roach, M.D., President; John P. Harrod, M.D., President-Elect; Vincent C. Freda, M.D., Vice-President; Robert E. Lane, M.D., Secretary; John C. Buckingham, M.D., and Mario D. Oriatti, M.D., Treasurer.



ISMS Receives Hippocrates Tree

The Illinois State Medical Society has received a sapling grown from a seed from the famed Tree of Hippocrates on the Greek Island of Cos. The young tree was presented to ISMS Executive Administrator Roger N. White, (left) by Robert W. Link and Bernard Friedman of Schering Corporation.

The pharmaceutical firm has purchased hundreds of the trees for presentation to medical schools, teaching hospitals, medical societies and specialty organizations. Through purchase of the trees, Schering is helping to provide funds for the Medical Foundation of Cos.

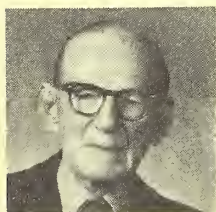
The Tree of Hippocrates is believed to be more than 2,400 years old. Hippocrates, a physician of ancient Greece who is considered the "father of medicine," is believed to have taught his disciples in the shade of this ancient sycamore.

Two Physicians Together Complete 120 Years of Service

Mark Greer, M.D., Vandalia and Edwin S. Hamilton, M.D., Kankakee, together have completed 120 years of service as physician-surgeons. Their medical careers began during the horse and buggy days and have spanned through to the technology era. Performing surgery on a kitchen table or walking several miles to deliver a baby didn't deter these two physicians from serving the residents of Illinois.

Mark Greer, M.D.

In 1955 the Illinois State Medical Society honored Mark Greer, M.D., as "The Doctor of the Year." In his nomination for this award by the Fayette County Medical Society, Dr. Greer was not only cited for his contributions to the medical profession, but also for his years as a civic leader and philanthropist.



M. Greer, M.D.

The 84-year-old, semi-retired physician, began his medical career 60 years ago in Vandalia. In 1925 Dr. Greer, with the help of the Vandalia Chamber of Commerce and civic organizations, built the Mark Greer Hospital, which served for over 10,000 operations and 6,000 baby deliveries. His wife, Iris, a Registered Nurse, served as superintendent at the hospital. Miller Greer, M.D., assisted his brother in operating the hospital until its closing in 1955, when the Fayette County Hospital opened. Dr. Mark Greer was instrumental in the creation of the county hospital and served on the building committee.

Dr. Greer served for 15 years on the Illinois State Hospital Advisory Board under three governors. For

20 years he was President of the Fayette County Tuberculosis Sanitarium Board. His professional memberships include the Fayette County Medical Society, the Illinois State Medical Society, the American Medical Association, the International College of Surgeons and the Society of Abdominal Surgeons.

As a community and civic leader, Dr. Greer was a member of the Vandalia Board of Education for 25 years, of which he served 15 years as president. He is a 63-year member of the Masonic Lodge and a 53-year Shriner. Dr. Greer was Post Commander of the Crawford-Hale Post 95 of the American Legion.

The philanthropist, Dr. Greer, donated 20 acres of valuable land for the building of the Vandalia High School and deeded 13 acres adjacent for the swimming pool and baseball field. Dr. Greer gave 200 acres for the Marill Girl Scout Camp, named after his daughters, Mary and Jill. Each year Dr. Greer gives monetary gifts to all the Vandalia churches to help spread "Christmas cheer" for the children.

"His gestures as a physician, philanthropist and community leader have touched many a man, woman and child in the Vandalia community," quotes an editorial recently published in the *Vandalia Leader*.

Edwin S. Hamilton, M.D.

After 60 years of service as a physician-surgeon and a leader of organized medicine, Edwin S. Hamilton, M.D., is retiring. He has served the community of Kankakee as a "hometown" doctor who has delivered over 2,000 babies and served as the first Chief of Staff at St. Mary's Hospital.

As a tribute to this physician, teacher and Past President of the Illinois State Medical Society, each year an outstanding medical teacher in Illinois is selected to receive "The Edwin S. Hamilton Interstate Teaching Award." The recipient is chosen by the ISMS Council on Education and Manpower.

Dr. Hamilton has served many years in organized medicine. He was President of the Kankakee County Medical Society, and was President of ISMS during 1960-61. For 12 years he was Chairman of the Medical Examining Committee, which he found most rewarding.

During 1932-36, Dr. Hamilton served as an alternate delegate to the American Medical Association, and from 1936-48 he was a member of the AMA House of

Delegates. For 10 years he served on the AMA Board of Trustees and held the positions of chairman and secretary.

Dr. Hamilton was a founder of the World Medical Association and a member of its board of directors for 10 years. During these years of leadership, Dr. and Mrs. Hamilton traveled to India, Australia, Japan and Europe.

His other professional affiliations include the International College of Surgeons and the Interstate Post Graduate Medical Association of North America.

Dr. Hamilton has many rewarding memories of his years as a physician and attributes another greater source of satisfaction to his wife and family. Dr. and Mrs. Hamilton have two children and one grandchild.



E. S. Hamilton, M.D.

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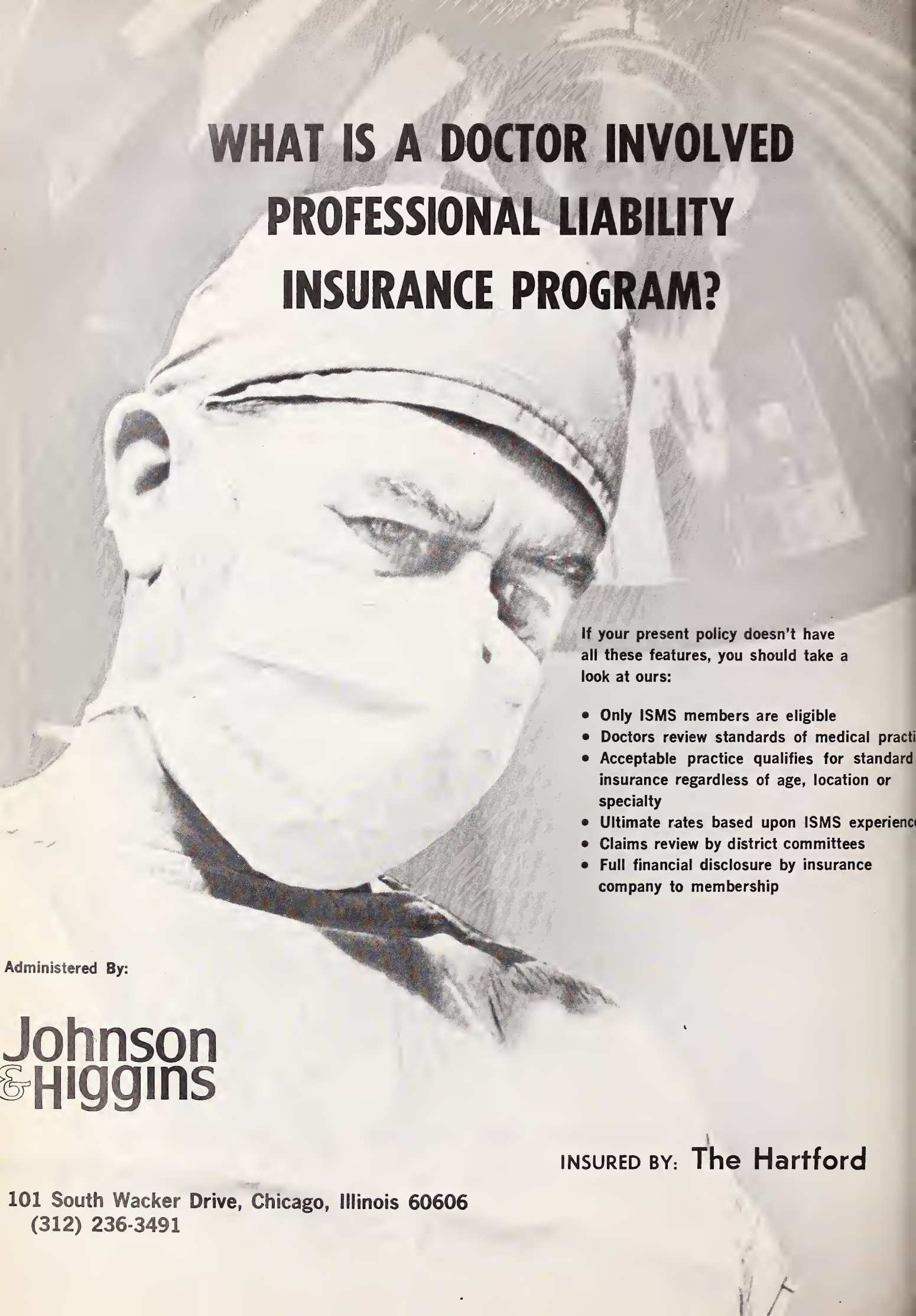
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Leadership Conference

Sunday, October 21, 1973

Drake Hotel, Chicago

Medical malpractice litigation, government influence on medical practice and physician involvement in politics will be spotlighted during the 1973 ISMS Leadership Conference next month.

More than 300 physicians are expected to attend the all-day program on Sunday, October 21, at the Drake Hotel in Chicago.



C. A.
Hoffman, M.D.

Keynote speaker will be C. A. Hoffman, M.D., immediate past president of the American Medical Association and a member of HEW's Commission on Medical Malpractice. Dr. Hoffman made news early this year when he filed a dissenting report after the commission listed more than 100 recommendations intended to resolve professional liability problems. Dr. Hoffman said the recommendations would do little to ameliorate problems and, in fact, probably would stimulate more claims.

A highlight of the conference will be the re-enactment of part of an actual malpractice trial. The dramatization will be presented by the Medical-Legal-Dental Relations Committee of the Illinois Bar Association and will be followed by a panel discussion of guidelines avoiding malpractice suits, and for the physician who is required to defend himself in court.

Government regulations of medical practice is the subject of a motion picture to be presented by Smith, Kline & French during the luncheon hosted by the pharmaceutical firm.

During the afternoon session, state government officials will discuss health programs in Illinois and answer physicians' questions about government regulation and activities.

Conference Chairman Jacob E. Reisch, M.D., of Springfield urged physicians to register early for the Leadership Conference.

Navy Capt. Joseph P. Kerwin, M.D., a member of the Skylab I astronaut crew and a native of Oak Park, Ill., will be presented with honorary membership in ISMS during the Leadership Conference. Although he is one of the nation's best-known physicians, Dr. Kerwin is not a member of any medical society or association. A Northwestern graduate, he entered the Navy immediately after completing his internship in a Washington, D.C., hospital.



Capt. J. P.
Kerwin, M.D.

I will attend the ISMS Leadership Conference, October 21, 1973 Drake Hotel, Chicago

Enclosed is my check for \$.....registration (\$5.00 per person)

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Editorials



Selecting Medical Students

In most countries, the majority of medical students come from urban areas and from professional backgrounds. Only a few come from rural communities, ghettos, or from working-class origins. This may explain why few doctors are willing to work in rural or unattractive industrial areas. To change this situation, we may be forced to alter our initial phase of the selection process.

There are enough applicants to set aside a pool of young men and women who come from rural and industrial areas. These students have a better understanding of the emotional and social aspects of illness, chronic diseases, and long-term disability characteristic of the poor of our society. They are better prepared to practice this type of medicine than the student who goes into medicine for financial gain or social status. Many physicians practicing in smaller communities believe that our medical schools are graduating too many doctors who are ill prepared to practice the kind of medicine that most communities need, especially in areas that do not attract professional people.

This means changing the criteria used by medical schools to select students. I am not trying to downgrade our present methods of evaluation, considering that 95% of those accepted to medical school go on to complete their training. But the admissions' committees of many schools could pay more attention to the applicant's attitudes, values, and motives, and less to his premedical grades and aptitude tests. Special arrangements could be made to admit some students who do not have the intellectual ability or academic attainments set as a formal policy of the school. In this way, more students from remote rural areas could be trained with the understanding that they will return for a specific

time, or better—permanently. I understand that this is being done with success in Illinois. Since 1948 the Illinois State Medical Society and the Illinois Agricultural Association have jointly co-sponsored a Student Loan Fund. By this, individuals from Rural Illinois who desire an education in medicine, but who lack financial ability, or are below educational attainment of graduates of the more richly endowed Chicago metropolitan area schools, are screened and recommended for admission to medical school. Loans also may be arranged. About 250 students have been accepted in Illinois medical schools, with 35 accepted for 1973. Compared to a control group drawn at random from University of Illinois medical school graduates between 1948 and 1964, nearly two-thirds (64%) remain in Illinois, half of these in rural areas; whereas more than half (52%) of the control group have left the state.¹

A certain degree of intelligence and motivation is needed to get through medical school. It is a frustrating experience for the student who does not have the background to pass biochemistry, physiology, or anatomy. By the same token, our schools should not prepare a curriculum that overtaxes their educational system. Medical educators are easily diverted from their primary task of ensuring that their students acquire the knowledge, skills and attitudes required of doctors today. There is a place for less ambitious applicants with more altruistic attitudes. ◀

T. R. Van Dellen, M.D.
Editor

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1. "Evaluation of a Program Designed to Produce Rural Physicians," Mattson, Stehr and Will, *Journal of Medical Education* Vol. 48, No. 4, Apr. 1973, pp. 323-331.



Placidyl® (ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

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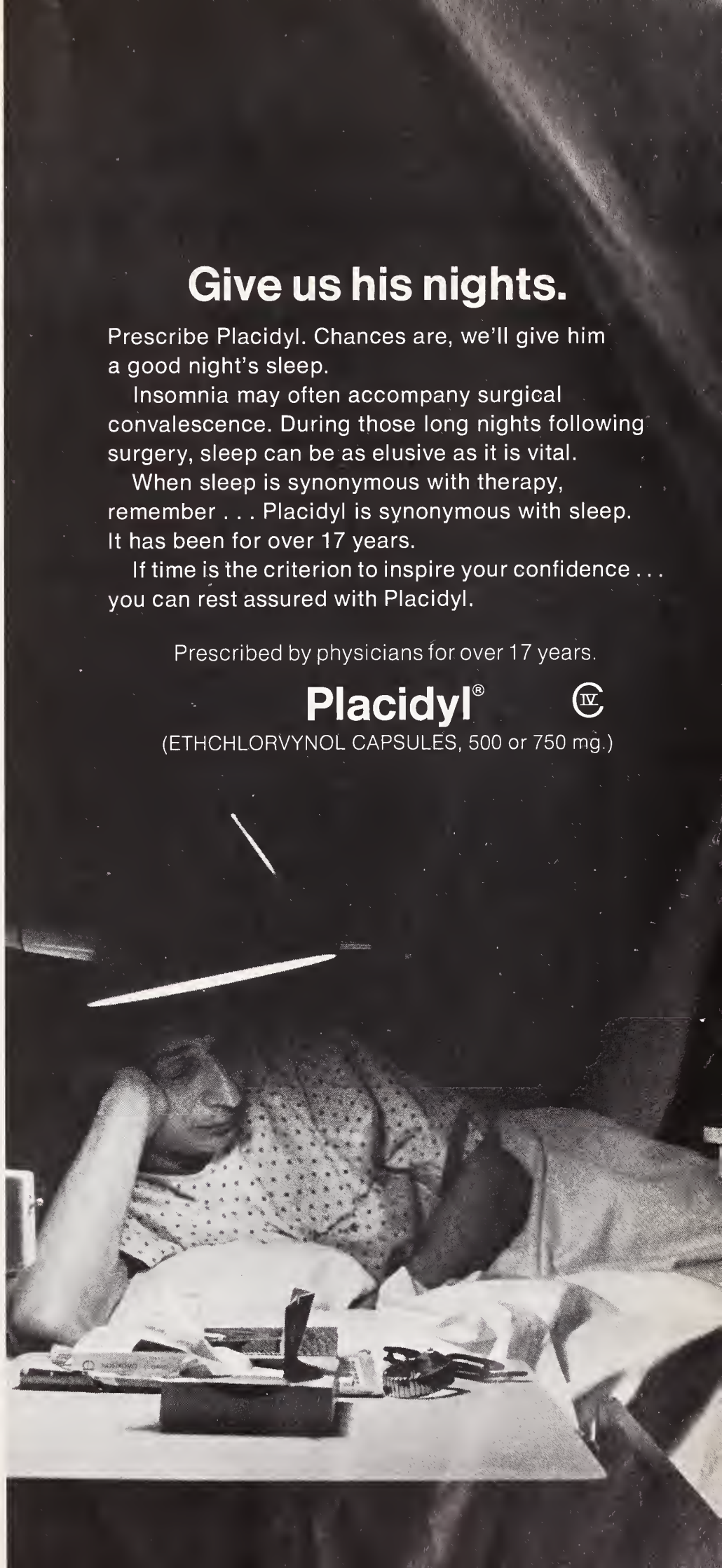
When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

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Herman von Helmholtz, 1821-1894

Physician, Musician and Versatile Scientist

BY E. LEE STROHL, M.D., WILLIS G. DIFFENBAUGH, M.D.
and ROBERT W. JAMIESON, M.D./CHICAGO*

Herman Ludwig Ferdinand von Helmholtz was born in Potsdam, Germany, on August 31, 1821. He was the son of Ferdinand Helmholtz, a teacher of physiology and philosophy in the Gymnasium. His mother was the daughter of a Hanoverian military officer, by the name of Penne, a lineal descendant of William Penn, the founder of Pennsylvania.¹

As a young boy, he was very delicate—almost an invalid—which restricted his activity, and bed rest was necessary to conserve his strength. His parents devoted a great deal of thought, time, and attention to their son, reading the classics, and developing his mind in their intellectual home life.

Herman occupied his time with reading, and with toys. Among the favorite was a set of wooden blocks, from which he developed some geometric designs—the first evidence of his mechanical genius.

When his health improved he was able to go to school, and he had a good general education. At the age of eight, he astonished his teachers by his knowledge of many fundamental truths.

The boy's desire was to concentrate on the study of physics, but his father pointed out that to work on pure science would provide only a precarious livelihood. He, therefore, suggested to him that he study medicine.

Through the assistance of a relative, at the age of 17, Helmholtz was admitted to the Royal Medico-Chirurgical Frederick Wilhelm Institute of Medicine, an academy for the medical education of youths of superior ability. No tuition was charged at this school; but it was with the proviso that on graduation the students would become surgeons in the Prussian Army.

Productive Scientific Career

He graduated when he was 21-years-old, and became a surgeon in the Red Hussar's Regiment; but not in the usual role of an Army Surgeon. It was a unique experience for him in that a laboratory was created at Potsdam which launched a productive scientific career for Helmholtz. Until his death, 50 years later, he pursued an illustrious work life of scientific disciplines, such as physics, physiology, pathology, anatomy, thermodynamics, ophthalmology, hydrodynamics, acoustics, nerve energy, color vision, and clinical medicine.²

Although Helmholtz did not engage in private practice, his pursuit in scientific disciplines, above enumerated,

as well as his service as Assistant Physician at LaCharite Hospital, is evidence that he was eminently qualified as a physician.

During the greater part of the period from his graduation in medicine, in 1842, until his appointment to the Chair of Physiology, in Koenigsberg, in 1849, Helmholtz resided in Berlin. He completed his term of service as Assistant Physician at LaCharite Hospital, and in 1843 he returned to Potsdam, where he carried on his duties as Assistant Surgeon to the Regiment of Hussars.

He came under the observation of Alexander von Humboldt, that great man, who recognized his superb intellectual capacity, and through his influence Helmholtz was relieved of his military duties, and became Assistant to the Anatomical Museum, Lecturer on Anatomy to the Academy of Arts, and Extraordinary Professor of Physiology at the Albert University. In the two latter appointments, it is interesting to know that he succeeded his friend, Ernst Brucke, who subsequently filled with great distinction the Chair of Physiology in Vienna. There is little doubt that the appointment to the Academy developed his mind in diversified fields, so apparent in after years. Helmholtz's research, however, was not anatomical, but physiological and physical.

He was at Koenigsberg until 1856, when at the age of 35 he became Chairman of the Department of Physiology at Bonn. He held this position until 1859, when he accepted the chairmanship of the Department of Physiology at the University of Heidelberg, and remained there until 1871. He was called, in 1871, to occupy the Chair of Physics in Berlin, where he remained until his death in 1894.

Inventor of the Ophthalmoscope

In 1851, when he was 30 years of age, Helmholtz invented the ophthalmoscope, based on his knowledge of medicine and physics. When the world-renowned ophthalmologist, von Graefe, was shown the instrument he is said to have exclaimed: "Helmholtz has unfolded to us a new world."

*From the Department of Surgery at Rush-Presbyterian-St. Luke's Medical Center, Chicago

During the period 1855-1866 he wrote his three-part treatise "Physiological Optics." This is considered to be the most important work on physiology, pathology and physics of vision. In 1862, he published his work on "Sensations of Tone," termed the "principia of physiological acoustics."³

Helmholtz, the Musician

In considering Helmholtz as a musician, music might be termed his alter ego. Since his days were spent in academic work, which was largely scientific, he enjoyed evenings with congenial company, and particularly evenings of music, in which he participated. He was an accomplished pianist, and his ability had its foundation in his study of the theory of music. He was thoroughly acquainted with musical literature, especially that of his fellow countrymen, Beethoven, Brahms, Mendelssohn and Wagner. It would seem logical that the combination of his talents enabled him to effect a complement of music to science, and a complement of science to music.

His first paper on physical acoustics appeared in 1849, which was in general a review of work done by others up to that time. This publication was followed by many papers on tones of different characteristics, among which were Vocal Tones, The Theory of Open Organ Pipes, The Motion of the Strings on the Violin—and the most famous of these works "On the Sensation of Tones as a Physiological Basis for the Theory of Music." This 576-page volume was published in several editions, including translations from German into other languages, and is a fundamental textbook in its field. He was a great musical theorist, who invented a system of double harmonics, and developed the physical nature of musical sounds, which greatly facilitated teaching and appreciation.⁴

The ideas of Helmholtz were demonstrated to prove their validity, in furtherance of which he invented a special apparatus. This costly apparatus was presented to him by King Maximilian of Bavaria, which consisted of a harmonic series of forks, electrically driven, and so arranged that they could be sounded in any order and with various intensities.

Helmholtz's brain was continually dealing with the physiological effects of sound, particularly music. Frequently he awakened in the middle of the night, with the effects of sound on his mind, and on some of these nights it was necessary for him to satisfy his intellectual musical curiosity by playing Bach's Fugue on a magnificent grand piano, which had been presented to him by the Steinways of New York, in recognition of his services to music.

Upon his arrival in Heidelberg, in 1859, he studied the anatomical effects, and their relationships, as they apply to the production of musical sounds. His study of the ear led him to the physiological research on sensation of the tone of music in the ear.⁵

During the 11 years he was at Heidelberg, 1859-1871, he was prolific in the writing and publication of papers. He contributed 60 papers, and delivered a great number of lectures, both home and abroad.

His Last Years

In the last years of his life, Helmholtz devoted considerable time and attention to the affairs of the Technical Institute. The Emperor William I often invited Helmholtz to the Royal Palace to discuss with him

some of the most recent advances in science. He was also an intimate friend of the Crown Prince Frederick, afterward Emperor, who was deeply interested in everything relating to the Art of Science.

Honors came to Helmholtz from all parts of the world, and on his 70th birthday he received many tributes of esteem. The Emperor William II sent him an autographed letter, in acknowledgement of his great service to science, and conferred special honors on him. The Kings of Sweden and Italy and the President of the French Republic sent him the insignia of various Orders. A Helmholtz gold medal was struck in his honor, to be awarded, from time to time, for distinguished service to science, and, at a banquet, Helmholtz was the first recipient.

His scientific colleagues hoped that he had many more years of activity. This was borne out by his attending and addressing the British Association for the Advancement of Science in 1892, and his visit to the Columbian Exposition in Chicago, in 1893.

On the return voyage, as his ship approached Hamburg, he had an attack of dizziness, and fell down the stairway of his cabin. The injury was severe, producing concussion of the brain, and a great loss of blood from the scalp wound. He made a slow recovery. Nevertheless, his friends saw him failing in strength. His work became much more of a chore, and it was very difficult for him to perform. Eventually, the brain, which had worked so well over so many years in diversified fields, failed in July, 1894, when he had an apoplectic stroke. He lingered for a period of two months, and died on September 8, 1894, at the age of 73.

Acknowledgement

It was the good fortune of the senior author to be associated with one of his lineal descendants, Dr. Frederick Helmholtz, during my fellowship in Surgery at the Mayo Clinic. Dr. Helmholtz possessed many of the characteristics of his ancestor, Dr. Herman von Helmholtz. It was at this period of time that I was introduced to the work of Dr. Herman von Helmholtz, inventor of the ophthalmoscope, which is used daily throughout the world.⁶

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6. Personal Communication to the Senior Author, E. Lee Strohl, M.D.

In Gonorrhea

Injection WYCILLIN® (sterile procaine penicillin G suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae*: acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity.

Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisypilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by deep intramuscular injection, in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated) — Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae*. Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages.

And destroy another link in the chain of infection.

In Syphilis

Injection

BICILLIN® Long-Acting
(sterile benzathine penicillin G
suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually •cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If

allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisypilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

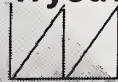
Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

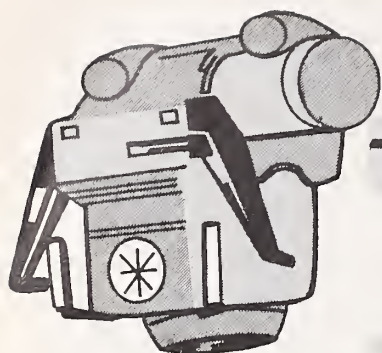
Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by deep intramuscular injection in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Figure 1



Figure 2

This is a 68-year-old female who entered the hospital with symptoms of constipation of three days duration and diffuse abdominal pain over the entire abdomen. A colon examination was done, (Figure 1 and Figure 2).

There had been a prior report from another institution that the patient had a calcified gallstone.

What's your diagnosis?

(Answer on page 253)

October, 1973, is Immunization Month

Based on a Conference of the Promotion of Immunization, sponsored by the Center for Disease Control, Atlanta, Ga., Report FF of the Board of Trustees recommended designation of October, 1973, as "Immunization Month." This report was adopted by the AMA House of Delegates at the Annual Meeting in New York, June, 1973.

By this, all physicians are encouraged to review the immunization status of their patients and act to increase the immunization level of

pre-school children against preventable diseases. In 1964, for example, 87.6% of children 1-4 years of age in the U.S. were immunized against polio; in 1972 only 62.9% were so immunized. Comparable data for DPT are 76.0% in 1964 and 75.6% in 1972.

Declining levels of immunity are of concern to the medical profession. Physicians are encouraged to review their patients' records and parents are especially urged to discuss immunizations with their physician.

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Dx:

Acute Physician Need

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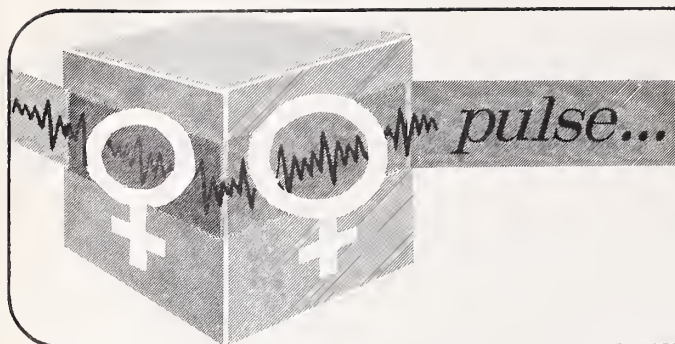
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ILM-9

The National Health Service Corps



pulse... of the doctor's wife

MRS. ROSANNE K. FRANK, *Editor*

From the President's Desk . . .

The man who said, "there's nothing new under the sun," was right to a certain extent, but there are creative and productive ways to enforce old ideas. It is always enlightening to attend the convention of the Woman's Auxiliary to the American Medical Association, and especially interesting are the periods of Idea Exchange.

In the field of Health Careers, several states use a *Health Careers Van*, which tours the state on scheduled trips. The Van also carries a puppet slide show on nutrition for grade and junior high school students. The VD film, "*A New Focus*," is on the Van for use on request. School councilors are sent packets on health careers or health education information two weeks before the Van is due at the school. Another state contributes to a *paramedical loan fund* through the state dues paid by members, and many young women have been aided financially. Illinois has established a *Health Careers Commission* in one community, working with the Americana Health Care Center, and eventually the commission will present programs to the schools in teams. It is hoped this type of coordination between health career agencies will be expanded throughout the state.

Legislative activities were enthusiastically undertaken with legislative "Learn-ins," southern breakfasts and informative tours.

Approximately 7,000 persons viewed exhibits and visited a booth during a Nutrition Week, when auxiliaries emphasized better nutrition for teenagers. Another Health Education project instituted *Project Compassion*, which dealt with caring for a resident in a nursing home. Meaningful friendships and attachments resulted from this avenue of service.

An open-line radio program, "*Your Doctor Speaks*," has proved invaluable on all subjects of health education. A state health education conference emphasized a format, "Finding Solutions for the Complex Health Problems of our Youth," and the support and interest grew to



Mrs. Robert Hartman

almost unexpected proportions. The recommendations and ideas which resulted from two days of workshop sessions were worthy building blocks for accomplishment. Georgia emphasized, *An Information Device* (AID), a survey of health services available, while Idaho gave assistance to retarded teenagers and older girls in a state school. Another state concentrated on a study of the quality of life, with the ultimate goal being to inspire awareness, action and the implementation of a *comprehensive health education program* in the public schools from kindergarten through grade 12.

Reports of interesting projects will be continued in a subsequent issue of the *IMJ*, and will be described in regard to health education projects in particular. Ideas in more detail will be presented at district meetings.

ADVANCE INFORMATION—Quality of Life Congress, April 1, 2, and 3, 1974, in Chicago (emphasis on aging).

Mrs. Robert (Bea) Hartman

“Search”

The councilors of the 11 auxiliary districts are busy in a special summer project for “Health Services Data Bank.”

Each councilor, with the help of her county presidents and auxiliaries, will prepare a brochure or list of health related services and agencies in their respective counties. This publication will contain the names, addresses and phone numbers of the health oriented community organizations eligible to assist residents.

Many counties have social and medical services which are available to citizens, but whose facilities are unknown to them. People seeking health information should have it readily available. The ideal goal is a 24-hour health information service.

At this writing the Auxiliary to Morgan-Scott County Medical Society has prepared, as a pilot project, a valuable brochure of its community services. The Committee on Health Care of the Poor in Cook County is preparing a list of health facilities therein. We foresee a statewide network of community services widely publicized by our auxiliary members through their local contacts.

District councilors will have their survey for each county ready for presentation at their district meetings in November, 1973.

We are sure each member will want to help her president and district councilor prepare a most complete and accurate list of health-related services and agencies in her county, thereby contributing substantially to our summer project “SEARCH.”

*Mrs. Joseph Shanks
Community Health Committee*

Notes from the Editor . . .

Important Dates:

April 3-6, 1974: Convention of Auxiliary at the Conrad Hilton Hotel, Chicago.

February: Health Education Conference in Chicago. The check given us by Mrs. Betty B. Pitcher is being put to good use here. Watch for further detail.

Jan. 14, 1974: Winter Board Meeting of Aux. Officers.

Nov. 8, 1973: Districts 9 and 10 meeting in Belleville.

Nov. 12: Districts 2, 4, 5, 6, 7, 8: meeting in Springfield.

Any more Let me know.

* * *

Legislative Scene:

Come this fall we shall be alerting you to activities in the state and national legislative halls which will need your support. REMEMBER: when you ask someone to do something, take the time to THANK them when you get some action. Our legislators are buffeted on all sides and need to know we support them. It would help if you sent copies of letters you get from your representatives to the ISMS office, this keeps them informed on what is happening “out yonder.”

* * *

News:

There will be four issues of PULSE, during '73-'74 plus the monthly insertions in the IMJ. The ISMS decided to subsidize this activity. To implement the publication an AdHoc Communications and Editorial Committee was formed consisting of four members, plus the editor. For a fall issue: WE NEED NEWS—NEWS—NEWS.

* * *

Members Serve on ISMS Councils:

The accent is on COMMUNICATION this year—and what better way for the Auxiliary to have opportunities to exchange ideas with the doctors than by serving on ISMS Councils. The following board members were appointed to ISMS Councils:

Environmental and Community Health:

Mrs. Joseph Shanks

Annual Meeting and Joint Management

Commission: Mrs. Carrell Hutchinson

IMPAC: Mrs. Alan Taylor

Governmental Affairs: Mrs. Paul Raber

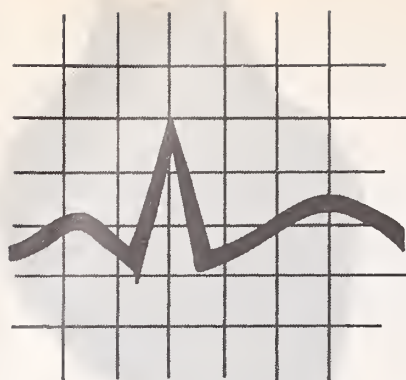
Public Relations and Membership Services:

Mrs. Donovan Stiegel

Public Affairs: Mrs. Harlan Failor

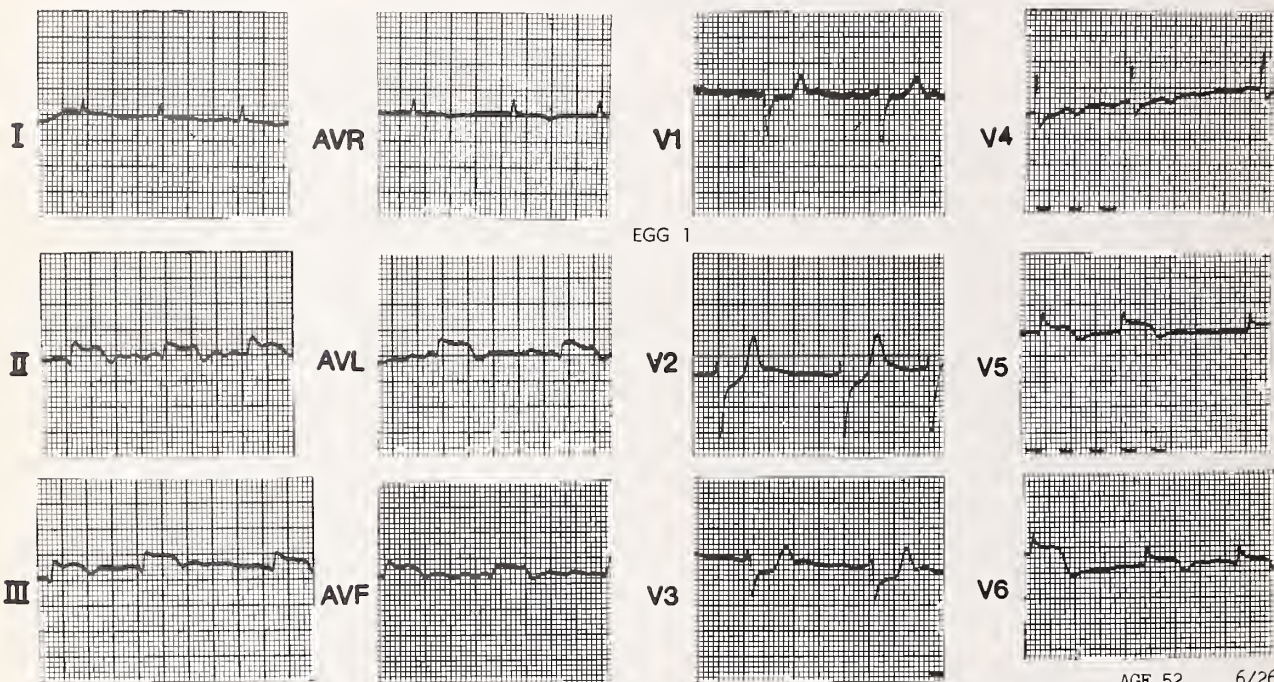
Advisory Comm. to Students and Physicians in Training: Mrs. Mitchell Spellberg

Mental Health and Addiction: Mrs. Ralph Davis



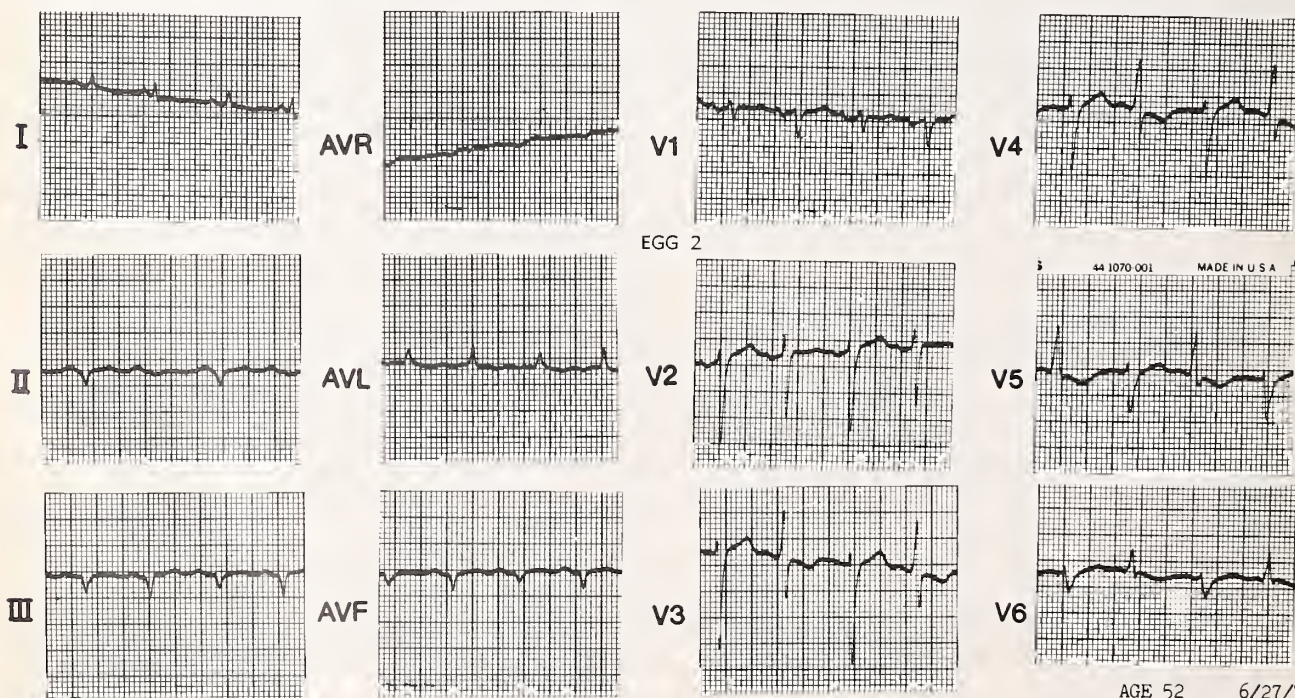
ekg of the month

JOHN R. TOBIN, M.D., M.S., RINGAUDAS, NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine



AGE 52 6/26/73

A 52-year-old man entered the emergency room with a one hour history of severe chest pain. The pain radiated to both arms and was accompanied by diaphoresis and palpitations. Two ECG's are presented from two successive days in the coronary care unit.



AGE 52 6/27/73

Questions:

1. The first ECG shows: A. Atrial flutter; B. Atrial fibrillation; C. Complete left bundle branch block; D. Acute inferior and lateral wall myocardial infarction; E. Acute anterior subendocardial infarction
2. The second ECG from the next day shows: A. Sinus rhythm; B. Premature ventricular beats in bigeminy; C. Bidirectional ventricular tachycardia; D. Alteration of the heart or electrical alternans; E. Alternating right and left bundle branch block

(Answers on page 253)



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report

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The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Surgery and Anticoagulation Therapy

(Continued from page 207)

Summary

Anticoagulation therapy has become a widespread mode of treatment. Usage of such drugs in a surgical patient is being advocated more and more, particularly when postoperative complications arise. The question of whether discontinuance of a particular drug prior to surgery has been often raised. This must be weighed with the potential complication of discontinuance as against the risk of hemorrhage at surgery. If anticoagulants are used in the surgical patient, and if they are to be maintained after surgery, it is of great importance that adequate surgical hemostasis be obtained prior to closure of the wound.

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Febrile Reaction of Gaucher's Disease

(Continued from page 230)

gested that the febrile episodes in Gaucher's disease represent an allergic response to liberation of an unidentified lipid pyrogen following bone injury. Therapy with varied immunosuppressive agents resulted in inconstant temperature reduction, while reserpine initially effected temperature reduction on three occasions, before becoming ineffectual.

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EKG of the Month

(Continued from page 248)

Answers: 1. B,D 2. A,D

Atrial fibrillation developed with the onset of this acute inferior-lateral myocardial infarction. The diagnosis is made by the irregular baseline, the irregularly irregular R-R cycle lengths, and the Q waves with ST segment elevation (current of injury) seen in leads II, III, avL, avF, V5 and V6. The patient was also in congestive heart failure. He was treated in the usual fashion and the next day he was in normal sinus rhythm. However, his heart failure was only slightly improved. Now he also had electrical alternans.

Careful examination will show a QRS duration always less than 0.12 seconds and essentially equal R-R cycle lengths. Equal R-R cycles, P waves preceding each QRS with equal PR intervals, and a changing QRS pattern every other beat make the diagnosis of electrical alternans (best seen in leads V1 and V2). Electrical alternans is frequently associated with mechanical alternans. Both mechanical and electrical alternans may well be related to beat to beat changes in the behavior of cell membranes and myocardial contractile elements. They are associated with severe myocardial damage seen in left ventricular disease, coronary artery disease, hypertension and aortic valvular disease. This is a rare ECG occurring once in 10,000

ECG's or less often. Alternation of the heart usually means a poor prognosis. The treatment is directed at the underlying cause. For a more detailed discussion see Bellet: *Clinical Disorders of the Heart Beat*, Lea and Febiger, 1971. ◀

View Box

(Continued from page 244)

Diagnosis—Gallstone Obstruction of the Colon. Figure 1 demonstrates a communication of barium to a structure in the right upper quadrant which has the appearance of a gallbladder.

Figure 2 demonstrates a radiolucent filling defect in the sigmoid which conforms to the size of a large gallstone. Apparently, the gallbladder had ruptured and the stone had directly entered into the right side of the colon and worked its way to the level of the sigmoid which was somewhat narrowed as a result of diverticula causing a complete obstruction clinically.

Gallstone obstruction is rare, comprising only 1.8% of acute large and small bowel intestinal obstruction. The small bowel is by far the most common site; next is the colon, either descending or sigmoid. Only about 2.4% of the obstructing calculi lodge in the sigmoid. If a calcified gallstone has been previously noted, and is not found at a future examination with obstruction present, the suspicion of a gallstone obstruction should be kept in mind. ◀

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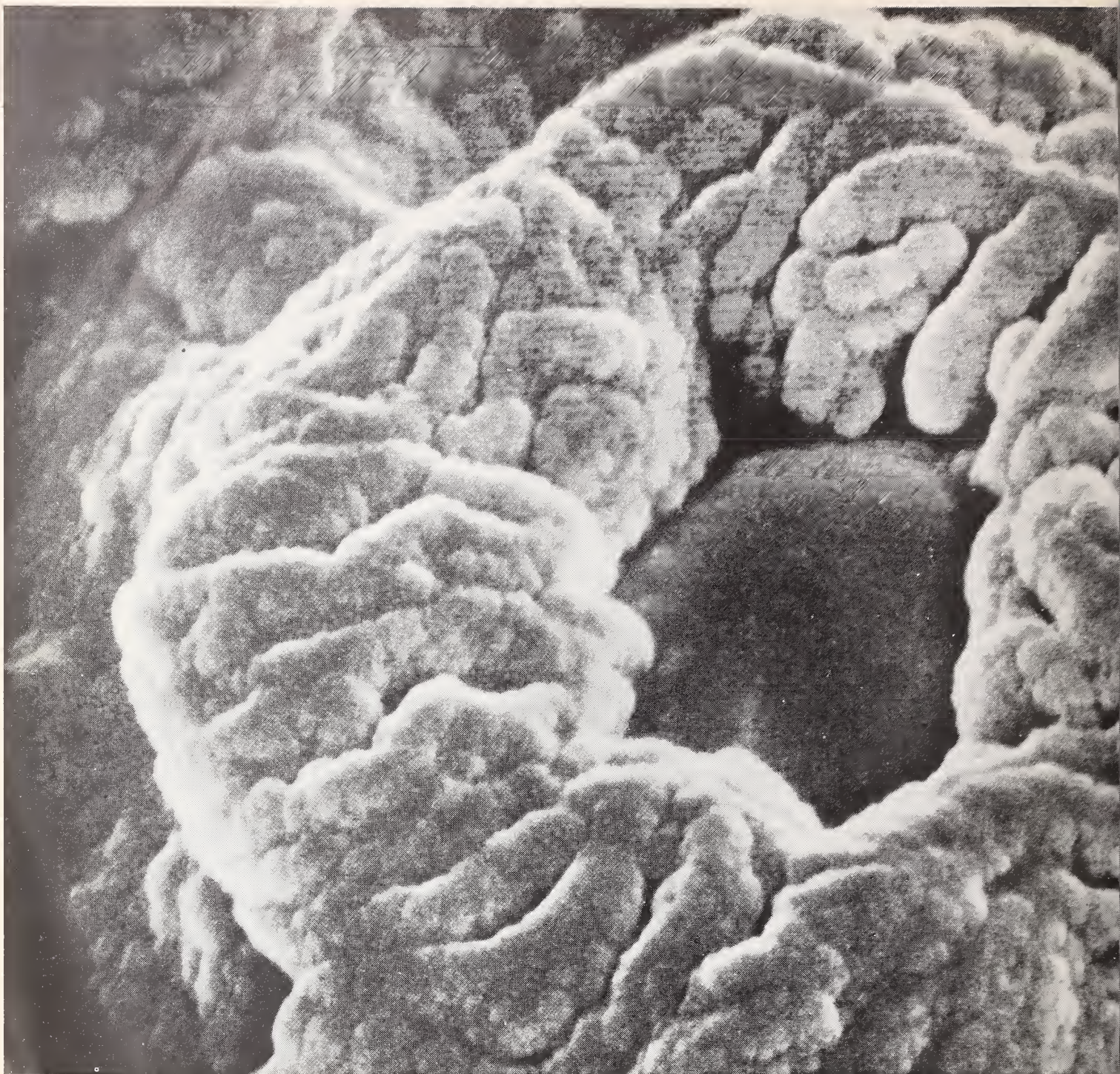
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This Scanning Electron Micrograph (7000 \times) is the first 3-dimensional view of a cell in an ulcerated duodenum. The center is completely denuded, surrounded by fairly well-preserved microvilli. This SEM photomicrograph was taken from a scientific exhibit which won the Hull Award as the "best exhibit on original research or instruction on a medical subject" at the A.M.A. Clinical Convention, November 26-29, 1972, in Cincinnati, Ohio.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-

prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been

The Tireless Man

whose duodenal ulcer needs a rest

Up early, home late, often with a scratch pad filled with notes, figures, plans. A few hours' sleep and then another long day. This is often the routine of the tireless hard-driver, one-man committee with enough overwork and stress to wear out several men. But his duodenal ulcer may warn him with sharp discomfort that he had better ease up, let some things go, and give himself—and his ulcer—a rest.

The need to reduce G.I. hypermotility and hypersecretion

Overwork together with overanxiety are often principal factors in exacerbating a duodenal ulcer. To help reduce the increased gastric secretions and hypermotility, therapy may need to include treatment for associated undue anxiety—which is where dual-action Librax can be highly useful.

The dual nature of Librax

Only Librax combines, in one capsule, the antianxiety action of Librium® (chlordiazepoxide HCl) and the antisecretory action of Quarzan® (clidinium Br). As an adjunct to a therapeutic regimen, Librax may help relieve both somatic and associated anxiety factors that often contribute to the exacerbation of duodenal ulcer symptoms.

Up to 8 capsules daily in divided doses

For optimal response, dosage should be adjusted to your patient's requirements—1 or 2 capsules, 3 or 4 times daily. Rx: Librax #35 for initial evaluation of patient response to therapy. Rx: Librax #100 for follow-up therapy—this prescription for 2 or 3 weeks' medication can help maintain patient gains while permitting less frequent visits.

For the anxiety-linked symptoms of duodenal ulcer adjunctive

Librax®

ROCHE

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes

in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Illinois Emergency Medical
Service System Status Report

(Continued from page 216)

a tactical decision was made to proceed initially along the line of categorization of emergency care facilities for the critically injured patient.

The Illinois Statewide Trauma-EMS System is now being further developed by integrating the following essential components: hospital categorization; communications; transportation; training and education of both professionals and the public; and program evaluation. These essential sub-systems are being integrated into a comprehensive package which supports improved patient care for all emergencies and will continue to improve patient care and survival for trauma and other major medical emergencies. ◀

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16th Annual Fall Conference
on Nutrition in Medicine

October 5, 1973

Sheraton Motor Hotel

Rock Island, Ill.

PROGRAM

Eugene F. Diamond, M.D., Program Chairman

10:30	Opening/Introduction	2:00	"Meat and Meat Extenders" William C. Sherman, Ph.D.
10:45	"Drug Induced Vitamin Deficiencies" Daphne A. Roe, M.D.	2:45	Coffee Break
11:30	Lunch	3:00	Panel on Nutritional Lifestyle and the Heart "Diet Fads and the Heart" William C. Connor, M.D. "Childhood Diet and Coronary Heart Disease" Lorraine Miller, Ph.D. "Vitamin E and Coronary Heart Disease" Robert E. Olson, M.D., Ph.D.
12:30	Afternoon Session Panel on Nutrition and the Athlete "Weight Gain and Loss in Athletes" Charles M. Tipton, Ph.D. "Changing Patterns of Female Athletic Participation" Mr. David C. Arnold "Drugs/Nutrition and the Athlete" Timothy Craig, Ph.D.	4:30	Adjournment

Sponsored by:

Illinois State Medical Society

Illinois Nutrition Committee

Illinois Heart Association

Illinois Department of Public Health

Blue Cross/Blue Shield

Mail Registration
Fee (includes
luncheon)—\$12.00
to:

Ms. Connie Hilton, R.D.
Director of Dietetics
Moline Lutheran Hospital
Moline, Illinois 61265

Obituaries

****Bailey, Percival**, Evanston, died August 11, at the age of 81. Dr. Bailey had been a retired professor of neurology and psychiatry. From 1965 until his retirement in 1967, Dr. Bailey was Director of Research at the Illinois Dept. of Mental Health. He received his medical degree from Northwestern University.

***Bucher, Ray E.**, Danville, died July 2 at the age of 62. A former obstetrician and gynecologist, he had practiced in Danville from 1938 until last year. Prior to that he practiced in Freeport. Dr. Bucher graduated from the University of Illinois School of Medicine in 1937.

****Feinberg, Samuel M.**, Highland Park, 78, died July 10. He was an allergist and professor emeritus at Northwestern University School of Medicine. Dr. Feinberg also was associate director of allergy research at Evanston Hospital with his son Dr. Alan R. Feinberg. He was a graduate of Rush Medical School, 1920.

****Fitzgerald, Gerald J.**, Evanston, died July 27. He graduated from the University of Toronto in 1923 and had been a physician for more than 50 years.

***Fox, Donald R.**, Chicago, died July 24, at the age of 46. Dr. Fox was a pathologist at St. Alexis Hospital, Elk Grove Village, and director of the hospital's laboratories. He graduated from Loyola University Stritch School of Medicine in 1952.

***Gowdy, Franklin K.**, Chicago, died August 15. He graduated from Rush Medical School in 1936.

***Halpern, Louis, Jr.**, Chicago, died August 19, at the age of 77. He was a pediatrician and author. Dr. Halpern was on staff at Michael Reese, Louis A. Weiss Memorial and Edgewater hospitals. He was professor emeritus of pediatrics at the University of Illinois College of Medicine, from which he graduated in 1925.

***Harvey, Roger A.**, Denver, died July 17, at the age of 73. He was past president of the American Cancer Society and its Illinois Division. A former Hinsdale resident, he had been a professor and head of the department of radiology at the University of Illinois Hospital and College of Medicine. He graduated from the University of Rochester, New York, in 1939.

***Lutterbeck, Eugene F.**, Chicago, died July 30, at the age of 63. He was a well-known radiologist and former president of the medical staff at Cook County Hospital. Dr. Lutterbeck was affiliated with 10 Chicago area hospitals as well as serving as an assistant professor of radiology at Northwestern University Medical School and President of the Institute of Medicine. He graduated from the University of Bern, Switzerland, in 1936.

***Morrison, Donald A.**, Chicago, died July 28. He graduated from Jefferson Medical College, Philadelphia.

****O'Neill, Christopher**, Chicago, died February 1. He had been a physician for more than 50 years, and graduated from Northwestern University Medical School in 1910.

***Paloucek, Frank P.**, Chicago, died June 30. He graduated from the University of Illinois in 1947.

***Raider, Jack**, Chicago, died June 21. He graduated from Loyola University Stritch School of Medicine in 1933.

***Sax, Daniel D.**, Chicago, died at the age of 58. He was a physician and faculty member of the University of Illinois College of Medicine. He graduated from Rush Medical School in 1938.

***Simkin, Maurice**, Chicago, died July 23, at the age of 77. He was a general practitioner on staff at Lutheran General, Deaconess, and Bethany Methodist hospitals. Dr. Simkin graduated from Rush Medical School in 1925.

***Turner, Horace E.**, Chicago, died July 13. He graduated from the Northwestern University School of Medicine in 1925.

*Denotes member of ISMS

**Denotes member of 50-year Club and ISMS



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COOK COUNTY

Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES—1973

- SPECIALTY REVIEW IN SURGERY, Part I, October 22
- SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, Oct. 22
- MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Oct. 1
- BLOOD VESSEL SURGERY, One Week, October 8
- PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Nov. 6
- DISEASES OF ESOPHAGUS, STOMACH & DUODENUM,
3 Days, Nov. 8
- SURGERY OF GASTROINTESTINAL TRACT, One Week, Nov. 12
- MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 29
- BASIC GYNECOLOGY, One Week, October 1
- BASIC OBSTETRICS, One Week, October 8
- ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 26
- BASIC ELECTROCARDIOGRAPHY, One Week, October 15
- BASIC INTERNAL MEDICINE, One Week, October 22
- ADVANCES IN INTERNAL MEDICINE, One Week, Nov. 26
- FAMILY PRACTICE REVIEW, One Week, October 8
- PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 30
- RECENT ADVANCES IN PSYCHIATRY, One Week, December 3
- BASIC DERMATOLOGY, One Week, October 15
- STATE & NATIONAL BOARD REVIEW, Basic & Clinical,
Nov. 4 & 12
- GENERAL PEDIATRICS, One Week, November 26

*Information concerning numerous other continuation
courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (10)

ALEDO: Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Forth Street, Aledo, 61231, 309-582-5156. (9)

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington, 61701, 309-828-6051. (1)

BRADLEY: Looking for replacement (male or female) in my general practice. Fully equipped including competent personnel. Open staff hospital privileges. Leaving for health reasons. Trade area of 90,000, 60 miles south of Chicago. Write Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CHICAGO: Local Medical Examiner, half or fulltime, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, G.P., or surgeon. Salary negotiable, excellent benefits. Call 431-4671 or write Room 708, 122 South Michigan, Chicago, 60603 for information. (9)

CHICAGO: Opening in welfare clinic, south side; no hospital work. Guaranteed salary. Good opportunity to work into a part-ownership. Contact: Robert C. Parro, Chicago Medical Center, Inc., 657 W. 79th St., Chicago, 60620, 312-994-0100. (11)

CHICAGO: The Cancer Prevention Center, a multiphasic health screening facility, seeks internists, surgeons, gynecologists for its comprehensive health examinations. Employment is part time. Interested physicians are invited to visit and apply. Please contact the office of Angelo P. Creticos, M.D., 33 W. Huron, Chicago, 60610, 312-944-4371. (11)

CHICAGO: Internist; an insurance company has an opening for the position of staff physician in its medical department. Full-time, fringe benefits, salary negotiable, office population. Contact: Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CLINTON: General Practitioners needed for rural community. Population 8,000. 50 bed JCAH hospital.

Located 25 miles from Bloomington and Decatur and 40 miles from Springfield. This community offers good schools and educational opportunities, recreational areas, and shopping areas within a short distance. Medical Staff needs your help. Contact: Dr. Charles Ramey, 215 East Main Street, Clinton, 61727, 217-935-2191. (12)

DANVILLE: Population 45,000; Drawing area more than 100,000. Primary need in General Practice-Family Physician, however many specialties also required. Excellent hospital facilities; many specialties well represented. Fine community, affiliation with the University of Illinois Medical School available. Office space available. Contact: W. N. McCormack, M.D., 812 N. Logan Avenue, Danville, 61832, 217-443-5362. (11)

DU QUOIN: Population 7,000, 75 miles South of St. Louis and 20 miles north of Southern Illinois University. 1 Surgeon and 1 General Practitioner & OB GYN. Excellent opportunity for both to build lucrative practice. Brand new hospital with all new equipment and facilities. Present hospital board and staff will support. Office spaces can be made available. Area has good recreational facilities, good school and shopping areas. Contact W. M. Thornburg, M. D., 111 W. Main St., Du Quoin 62832 618-542-2137. (9)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (9)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D. 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (9)

FREEPORT—Population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multi-specialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include \$50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALENA: Pop. 4,000. Family/General Practitioner needed to join three other FPs. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 80,000. Historical community offers very good school systems, numerous churches, and outstanding recreational facilities. Contact: Wilbur E. Johnson, M.D., 300 Summit Street, Galena, 61036, 815-777-0900. (11)

GENESE0: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (9)

GENERAL MEDICAL SERVICES, LTD ("Physicians-On-Call"): Emergency room, house call, clinic work available in 16 hospitals and clinics throughout State: Chicago, Peoria, Dixon, Bloomington, etc. Full-time or part-time work available. Contact G. M. Gnertner, M.D., 153 West Lake Street, Bloomingdale, 60108, 312-627-3404. (12)

HARRISBURG: 4 General Practitioners, Cardiologist, OB-GYN and Ophthalmologist wanted. Population of 10,000. Modern hospital to practice in. Please contact Carl L. England, Jr., Administrator, Doctors Hospital, Harrisburg, 618-253-7671. (11)

HARVARD: Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing area and financially sound. Sixty five miles northwest of Chicago, thirty miles east of Rockford. Community committee, including present doctors. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033, 815-943-5261. (9)

HERRIN: Int., G.P., ENT, Anesth. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

HOOPESTON: Organizing medical group, looking for obstetrician, internist, and general practitioner. Trouble free community of 8,000; stable economy, drawing area of 25,000. Well established practice. Contact: E. P. Kosyak, M.D., 847 E. Orange St., Hoopeston, 60942, 217-283-5557. (12)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (11)

LAKE FOREST: Internists, certified or eligible, needed to practice in fine north shore community, with excellent earning potential. University appointment desirable. Excellent hospital with all specialist medical staff. Contact: Steven L. Seiler, Lake Forest Hospital, Lake Forest, 60045, 312-234-5600. (9)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (9)

MACON: Thriving community of 1600. Five of seven nearby towns without resident physician. Adequate unfurnished building available. Assistance given to become established. Located 8 miles south of Decatur (two first-class hospitals). Excellent schools. Five churches. Contact: Olive Johns, 250 W. Ruby St., Macon, 62544, 217-764-3483. (11)

MINONK: Population 2,500. Serving a patient area of over 10,000. Opening in new Medical Clinic, Inc. Twenty-five miles from two Universities in Bloomington and in Peoria. Schools, churches and facilities nearby. Contact: H. T. Barrett, M.D., 200 E. Sixth St., Minonk, 61760, 309-432-2525. (10)

MONMOUTH: Services area population 30,000. Opening for General Practice and OB-GYN. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (9)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (9)

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265. (11)

OTTAWA: Population 20,000. 75 minutes from Chicago loop via Interstates. Completely equipped ground floor physicians office with adjacent parking space. Enjoy good living and recreation as well as congenial professional relationships. Entirely new 125 bed hospital due to open this October. No traffic, no smog, just excellent family living. Contact: E. R. Maierhofer, M.D., 226 W. Madison St., Ottawa, 61350, 815-434-7418. (12)

PANA: We need 2 physicians to practice general medicine in a friendly active community of 6,500. 45 minutes from Springfield or Decatur, 1½ hours from St. Louis. Economy is farming and light industry. 5 schools, 16 churches, parks, clubs, lakes, etc. Contact John Luff, Pana Hospital, Pana, 62557, 217-562-2131. (9)

PLYMOUTH: Population 800 plus large rural drawing area. Ten-year-old clinic & office building (large) available. Two closest hospitals 18 miles. Large Illinois University 18 miles. Golf course, hunting, fishing, etc. close by. Grade and high school in town. Contact: Ken Smith, Box 21, Plymouth, 62367, 309-458-6241. (9)

PONTIAC: Population 11,000, trade area 50,000. 100 miles south of Chicago on Route 66. Wanted: family practitioners. Office space available adjacent to hospital. Contact: Dale Budde, St. James Hospital, 610 East Water St., Pontiac, 61764 or call collect: 815-844-5134. (9)

ROSICLARE: G.P., Ped. Hospital serves 2 counties—approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (9)

SOUTHERN ILLINOIS: Southernmost Illinois Health Care Planning Council—Represents 76,000 population in southern Illinois, with 4 hospitals in the area. Picturist southern Illinois is proud of its recreational facilities, schools and Southern Illinois University within commuting distance. Office space and housing available. Contact: Ray Oxford, Planning Director, 421 N. Blanche Street, Mounds, 62964, 618-745-6528. (12)

STREATOR: Physician to join three other G.P.'s in general practice group. All privileges available in beautiful new hospital to qualified M.D. Modern clinic building, well staffed. Generous salary to start, full partnership available after trial period. Rotating office hours, night and week-ends off, vacation, etc. Contact: George Powers Jr., M.D. and James E. Gottemoller, M.D., 301 S. Bloomington Street, Streator, 61364, 815-672-2133. (10)

STREATOR: Family Physician needed to join 10 man (2 family physicians) multispecialty group in community of 20,000, with new clinic building across from hospital, excellent practicing facilities for energetic physician, full insurance benefits, guaranteed income; teaching opportunities. Contact: C. T. Hawkins, M.D., Streator Medical Clinic, S.C., 104 Sixth St., Streator, 61364, 815-672-0511. (12)

WENONA: General Practice Opening. Population 1,200. Several nearby communities without physicians. Only physician wanting to retire soon because of health. 15 miles from new St. Mary's Hospital at Streator. Office space and financial assistance available. Excellent schools. Contact: William Gilman, M.D., 407 1st North St., Wenona, 61377, 815-853-4511. (10)

WEST FRANKFORT: GP to take over well established practice in scenic Southern Illinois. Enjoy serenity of small town living, population 9,000, in center of rapidly expanding recreational facilities. Hospital in town. No investment needed. Call or write: C. E. Ahlm, M.D., 107 S. Van Buren, West Frankfort, 62896, 618-932-5015. (10)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Population 15,000. Two man corporation desires Generalist or Internist. Complete office facilities. 130-bed general hospital. Approximately 60 miles from Chicago. Salary open depending on qualification and experience, with partnership in 2 years if agreeable. Contact Dr. H. A. Stahlecker, Jr., & Dr. P. D. Exconde, 666 W. Jackson Street, Woodstock 60098, 815-338-2210 Collect. (9)

ANNOUNCING...

The 3rd Annual Doctor's Job Fair

9:00 a. m. - 4:00 p. m.
December 2, 1973
Sheraton-O'Hare Hotel
6810 N. Mannheim Rd. (Near O'Hare Airport)
Rosemont, Illinois 60018

FOR FURTHER INFORMATION - CONTACT:

Physician Recruitment Program
Illinois State Medical Society
360 North Michigan Ave.
Chicago, Ill. 60601

Abstracts of the Board of Trustees Meeting

(Continued from page 199)

dations affecting matters of policy or major changes in the IDPA Drug Manual.

The Board authorized the Council on Education and Manpower to include a representative of each medical school in Illinois. In order to reduce the size of this council the Council of Medical School Deans previously had been asked to name one member to represent all the schools. The schools requested that each be allowed a representative.

Appointments

The Board approved the appointment of Robert Becker, M.D., Joliet, as Chairman of the Relative Value Study Committee. Added to the RVS Committee was the chairman of the Illinois Foundation for Medical Care Committee on Uniform Administrative Procedures and Reimbursement Policies.

David S. Fox, M.D., will represent ISMS September 10-14 at a Hospital Medical Staff Conference at Estes Park, Colorado. Travel expenses for him and one staff member were authorized.

In the future, students and house staff members appointed to attend AMA meetings must be ISMS members if they are to receive expenses from the society.

Legislation

ISMS will sponsor a Legislative Day in Springfield next April or May, similar to the annual ISMS Washington (D.C.) Roundup. All members will be encouraged to participate. The Board also approved recommendations that ISMS oppose mandatory PAP smears for all hospitalized females and supported the drafting of legislation to reorganize the medical disciplinary system in Illinois.

ISMS will participate in a National Legislative Conference August 7-10 at the Drake Hotel in Chicago and will provide hospitality facilities.

Public Relations

Honorary membership in ISMS will be offered to Navy Commander Joseph P. Kerwin, M.D. a member of the Skylab crew and the first and only physician to make a space flight and to Charles M. Berry, M.D., the "astronauts' physician."

The Board endorsed the Boy Scouts of America Explorer health careers program and offered its support in Illinois.

A recommendation of the Public Relations Council that ISMS cease sponsoring and operating a State Fair exhibit in 1974 and subsequent years was approved by the Board. More effective use for the money previously spent for this activity is being planned.

Medical Services

The Board approved in principle the establishment of a 24-hour health information service and authorized further study of the concept. The proposal, which would expand an existing eight-hour program conducted by the Chicago Council for Community Services, consists of a telephone "hotline" through which residents of Metroloplitan Chicago obtain health information from trained volunteers.

In a related matter, the Board approved the principle of a nutrition education program for public welfare recipients and requested study of possible means of implementation.

Also endorsed was an AMA proposal to improve medical care and health services in penal institutions and juvenile detention facilities. ISMS will cooperate in implementing the program, which will include development of criteria from which local medical societies can evaluate health care in penal institutions in their area.

Benevolence

The Board was informed that the Woman's Auxiliary to ISMS had presented \$9,-182 to the Benevolence Fund. Letters of commendation will be sent to the Auxiliary congratulating the members on raising \$400 more than last year.

Hospital Licensing

In reporting the actions of the Illinois Hospital Licensing Board, William Lees, M.D., said it appears that several hospitals are planning construction of duplicate facilities in various locations. The Board ordered its Committee on Certificate of Need to increase its efforts to have suitable legislation enacted to prevent this duplication.

Medical Education

Illinois medical schools will be asked to report through the Council on Education and Manpower what steps they have taken to admit qualified foreign-educated American medical students in accordance with "Fifth Pathway" legislation passed by the General Assembly.

Matters Referred for Study and Recommendations

The Board referred the following matters to its councils and committees for study and recommendation:

1. Hospital satellites—Council on Social and Medical Services.
2. Robinson Incorporated's plan to feature ISMS in its advertising—Insurance Committee, with the Publications Committee having the right to approve ad copy if the principle is approved.
3. Opening ISMS membership to physicians working in Illinois on a six-month temporary license—Committee on Constitution and Bylaws.
4. Sending membership materials to "permit physicians" practicing in state institutions who are eligible for associate member status—Council on Public Relations and Membership Services.
5. Standardizing the election of ISMS delegates and providing representation for those societies not electing delegates—Committee on Constitution & Bylaws.
6. Proposals for a registration fee and development of a unified system of accounting for the Midwest Clinical Conference and ISMS Annual Meeting—Joint Management Committee.
7. Consideration of legal proceedings to force chiropractors to take the same examination as physicians—Executive Committee.
8. Project Hi-Blood, a comprehensive hypertension screening program conducted by the Daniel Hale Center—Chicago Medical Society, Board of Trustees.
9. Listing of medical information on the back of drivers' licenses—Council on Social and Medical Services for consultation with the Secretary of State's Office.
10. Guidelines for Peer Review Request from Third Party Payors—Council on Economics and Peer Review for alteration of proposed letter to health insurance carriers and then to Executive Committee for final approval.
11. Drafting of model health insurance policy—Illinois Foundation for Medical Care.
12. Definition of Medical Psychotherapy—Governmental Affairs Council for development of appropriate legislation and to the Policy Committee for development of a resolution to be introduced to the next House of Delegates.
13. Grant request from the Chicago Area Committee on Occupational Safety and Health—Council on Education and Manpower for investigation and, if approved, to Finance Committee. ◀

Gunshot Wound of the Back

(Continued from page 229)

of the cauda equina carry with them a prognosis that is not as bad as the one of the lesions in the cord itself. Secondly, there is the possibility of a hematoma at the site of the injury. Hopefully, by evacuating such a hematoma improvement could be achieved. As pointed out by Doctor Glista, the neurological deficit was not complete in the lower extremities. The patient did have some movement in the left quadriceps. Usually, a patient with a partial lesion has a much better prognosis than a patient with a complete lesion.

One might wonder why a myelogram was not carried out. It was felt that examination in this case was not necessary. The fragments of the bullet clearly outlined the level of the lesion within the spinal canal. Secondly, we would have had difficulty in performing a myelogram in this man because of the other lesion. It was also felt that precious time would be lost in the performance of this myelogram while the patient was bleeding in the abdominal cavity.

Regarding the prognosis for neurological recovery in this case, the final status is not clear

in this man. At surgery, some of the roots were completely torn. Obviously, these will not regain function. Some of the roots were badly contused. There is the possibility that some function might return to them. On the negative side of the prognosis, there is the fact that the conus medullaris was also involved.

Recovery from such a lesion would be most unusual. Should portions of the contused cauda equina recover, the recovery will occur very slowly. This being the case, recovery is still feasible, even after several months have elapsed. ◀

References

1. Richard Hardaway Meade: An Introduction to the History of General Surgery, W. B. Saunders Co., p. 19, 1968.

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NORTHERN AREA—Chicago office (no change)

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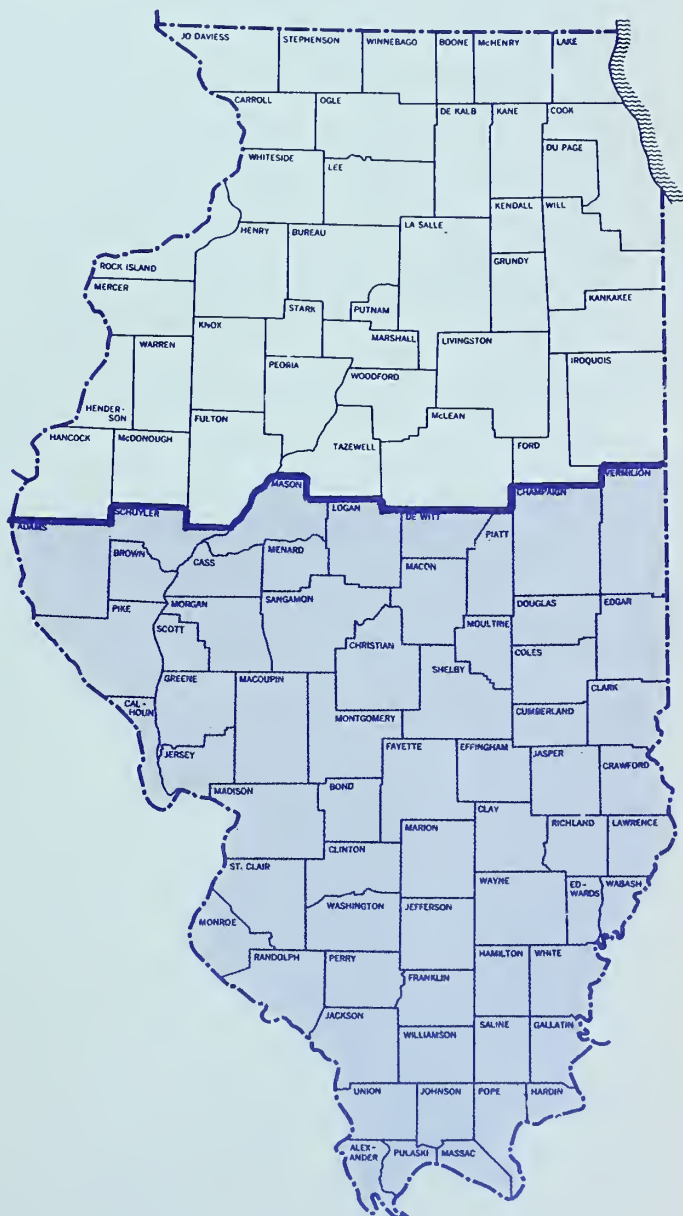
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(2) When a test or other laboratory service is referred from one independent laboratory to another, the laboratory performing the test must be certified in that specialty. The name of the laboratory actually performing the test should be made known to the physician and identified on the SSA 1490 form;

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OCTOBER, 1973

Vol. 144, No. 4

CONTENTS

Annual Reference Issue

- | | |
|-----|---|
| 304 | Principles of Medical Ethics |
| 305 | Constitution and Bylaws
<i>(Index on page 316)</i> |
| 326 | AMA Delegates |
| 328 | Officers of County Medical Societies |
| 334 | Trustee Districts |
| 336 | Councils of ISMS |
| 346 | Board Committees |
| 348 | Direct Reporting Committees |
| 351 | ISMS Services |
| 361 | Ancillary Organizations |
| 365 | Medical and Paramedical Education |
| 372 | Illinois State Government |
| 401 | Medical Legal |

(Index to Reference Issue page 408)

Surgical Grand Rounds

- | | |
|-----|--|
| 418 | Gastric Leiomyoma
<i>John M. Beal, M.D., Editor</i> |
|-----|--|

Pediatric Perplexities

- | | |
|-----|--|
| 421 | Idiopathic Pulmonary Hemosiderosis Anemia and "Pneumonia"
<i>Ruth Andrea Seeler, M.D.</i> |
|-----|--|

(Contents continued overleaf)

CONTENTS (continued)

Features

- 290 Clinics for Crippled Children
- 299 President's Page
- 413 Editorial
- 414 EKG of the Month
- 415 Doctor's News
- 425 Doctor's Library
- 426 Pulse of the Doctor's Wife
- 428 New Pharmaceutical Specialties
- 432 Membership Forum
- 435 Physician Recruitment
- 437 Obituaries

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and therapy for
other diseases
come into
conflict?



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The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

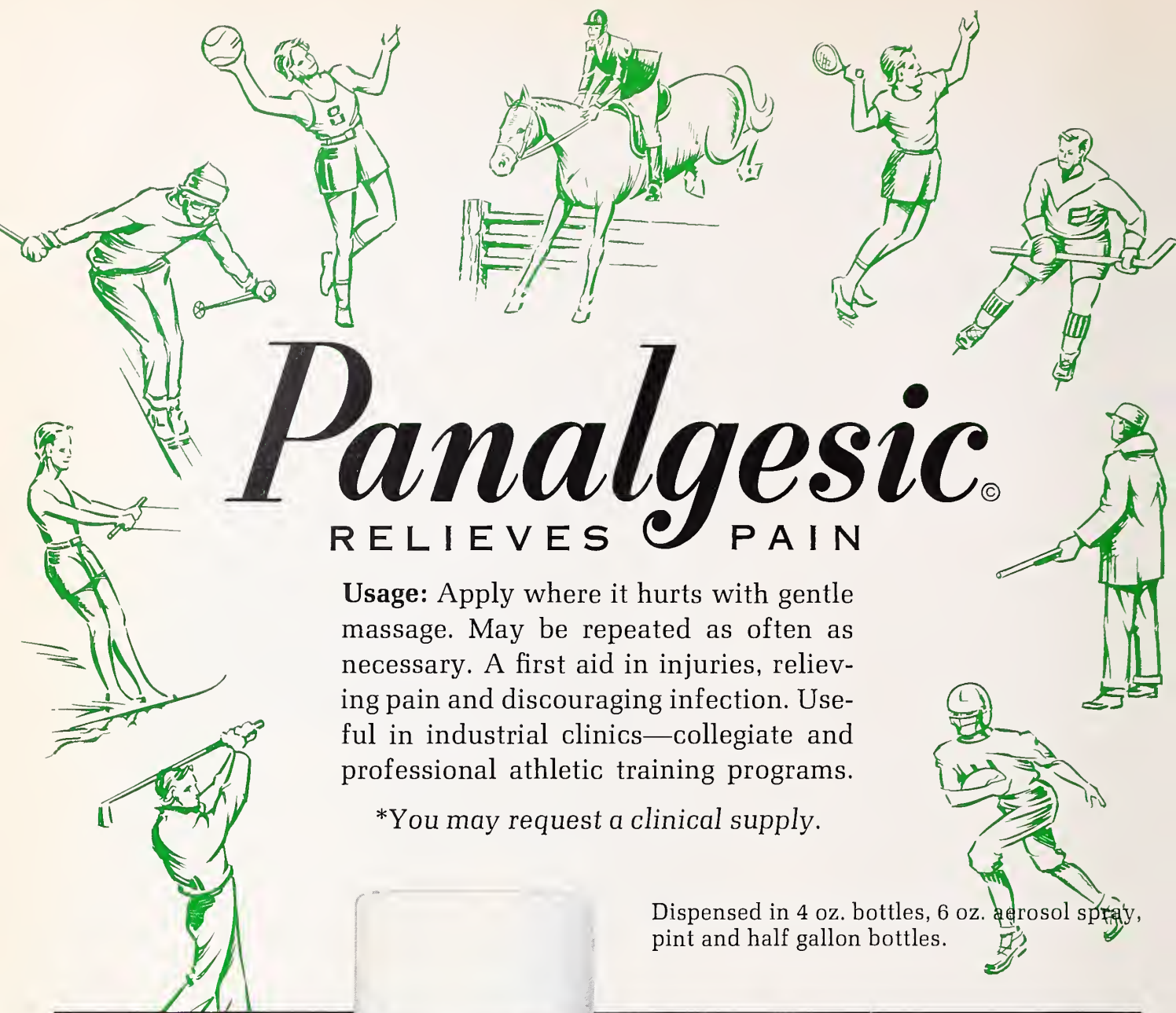
Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.



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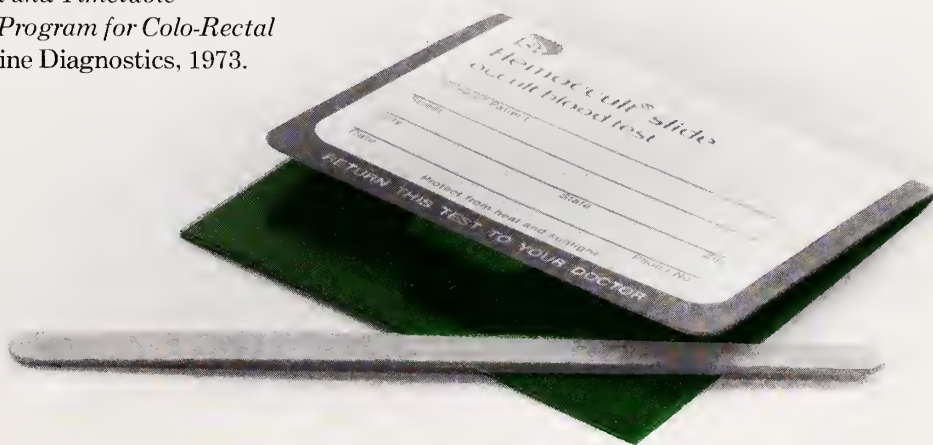
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Hastings, J.B., in *Organization and Timetable for a One-Day Mass Screening Program for Colo-Rectal Cancer*, Philadelphia, Smith Kline Diagnostics, 1973.



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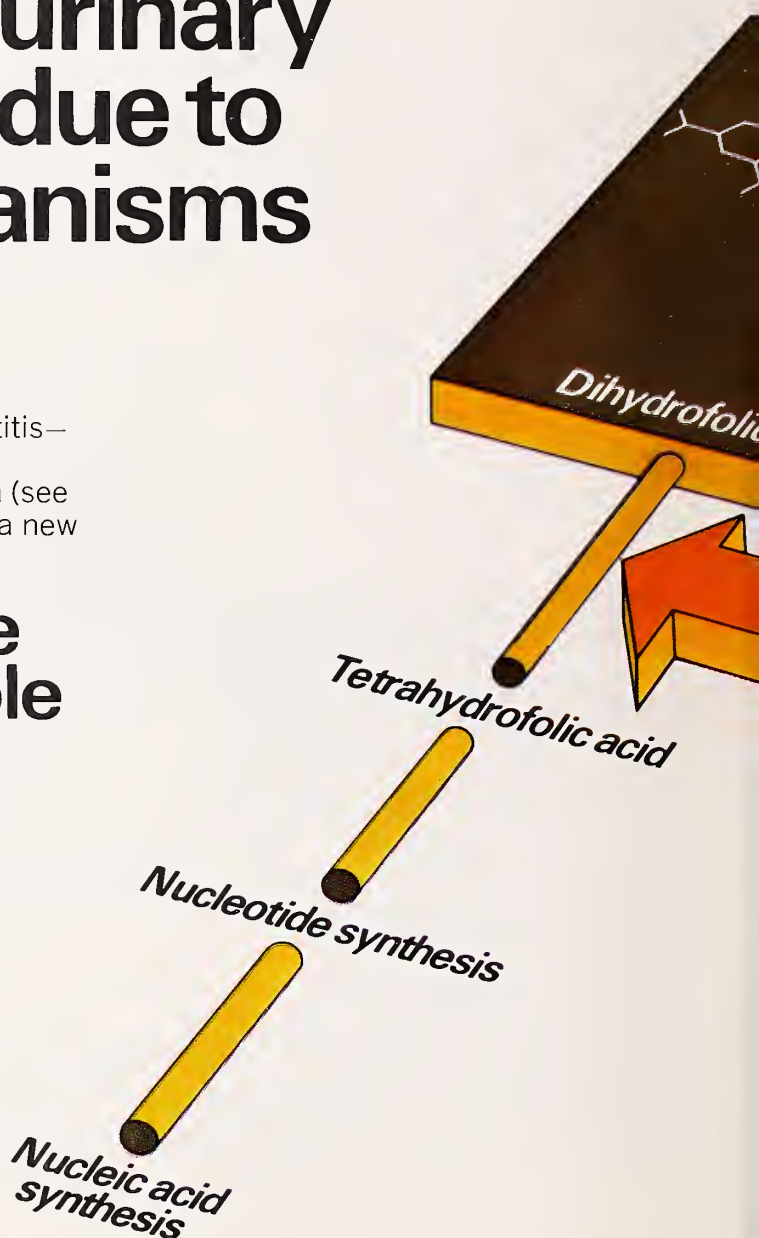
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

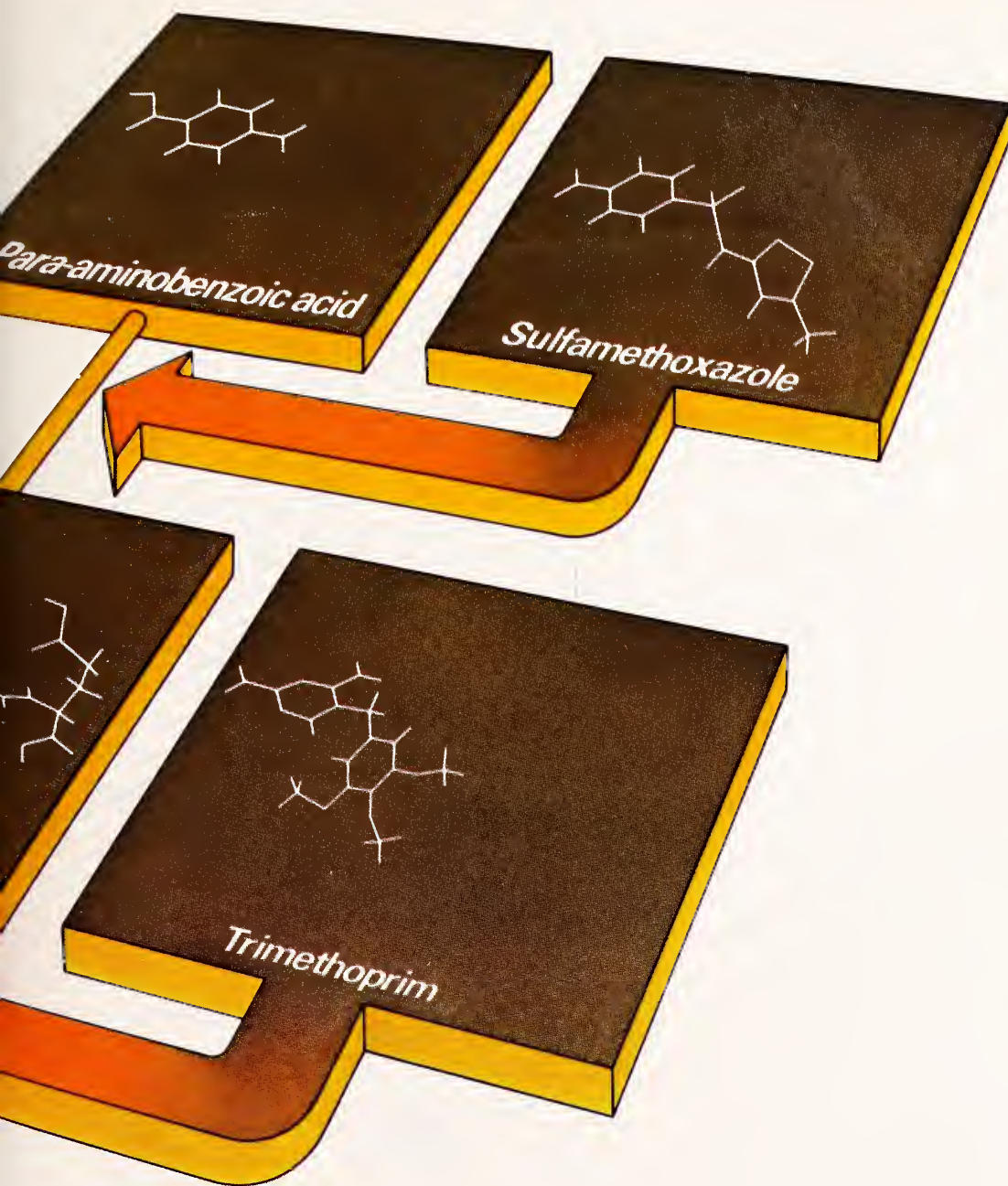
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





new **BACTRIM**^{T.M.}

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.
for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

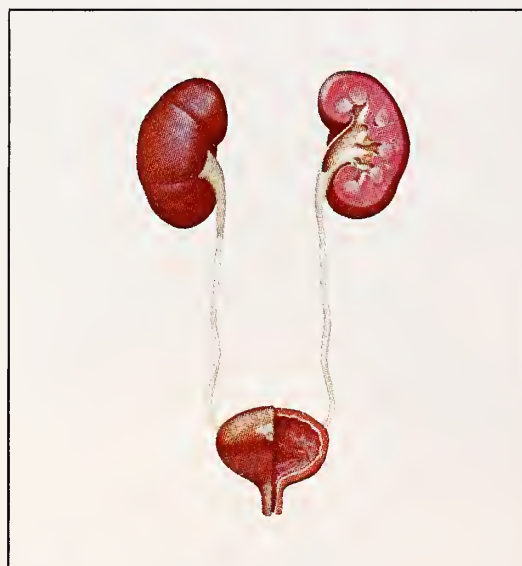
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

[†]4 patients not available for evaluation at day 10.



new BACTRIMTM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl)pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

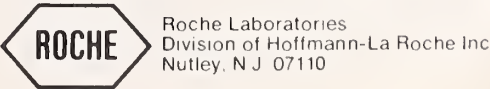
Creatinine Clearance (ml/ min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

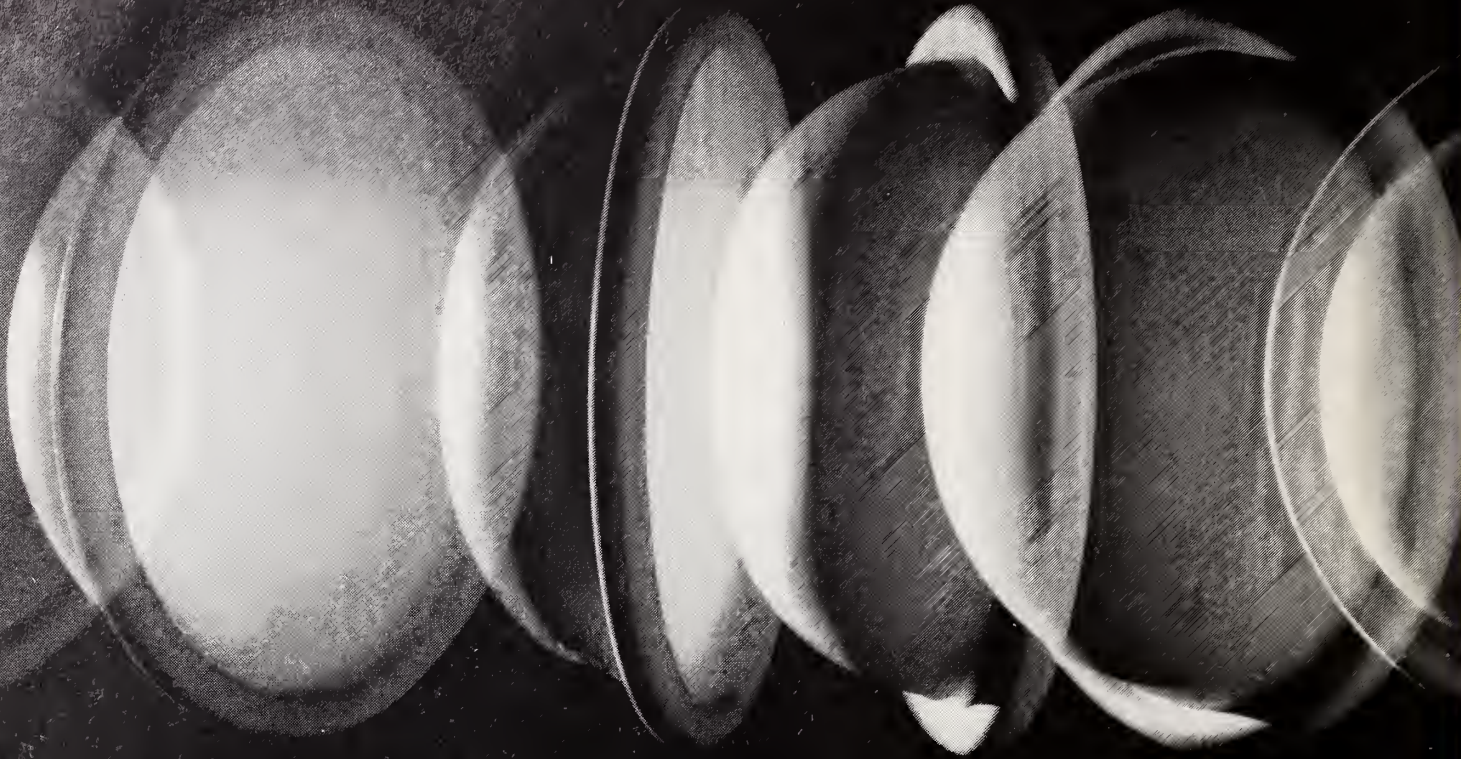
How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides

are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

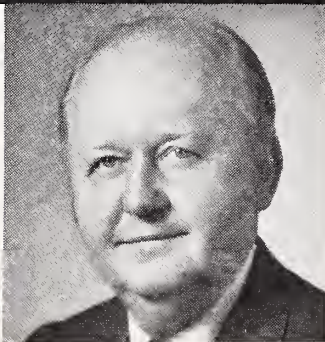
Dispenser of Medicine

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Maker of Medicine

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Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are *concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Physicians like the kind of prescriptions we write.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

Even if you want to borrow important money, like \$15,000 for new equipment. Or enough to buy that luxury item you've always wanted, take a long vacation, or for any other purpose you desire.

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with no red tape or hassle. Tell us what kind of deal you want, and we'll try to work it out for you.

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Banana-Flavored Donnagel-PG

The civilized solution to the age-old problem of diarrhea.

The evolution of Donnagel® PG:

Kaolin and pectin to provide demulcent-detoxicant effects.

Belladonna alkaloids for antispasmodic benefits.

Powdered opium, the therapeutic equivalent of paregoric—without the unpleasant taste—to promote the production of formed stools and lessen the urge.

And a delicious banana flavor good enough for the most discriminating tastes.

All together in the evolutionary discovery that's the best-tasting way yet to treat acute, non-specific diarrheas.

Donnagel-PG

Donnagel with paregoric equivalent.

Each 30cc. contains:

Kaolin 6.0 g.
 Pectin 142.8 mg.
 Hyoscyamine sulfate 0.1037 mg.
 Atropine sulfate 0.0194 mg.
 Hyoscine hydrobromide 0.0065 mg.
 Powdered opium, USP 24.0 mg.
 (equivalent to paregoric 6 ml.)
 (warning: may be habit forming)

Sodium benzoate
 (preservative). 60.0 mg.

Alcohol, 5%

☐ Available on oral prescription or without prescription in compliance with applicable state and local law.

A·H·ROBINS

IN WINTER COUGHS



CLEAR THE TRACT WITH THE ROBITUSSIN[®] LINE

Select the Robitussin[®]
"Far-Tract" Formulation
that Treats Your Patient's
Individual Coughing
Needs:

	Expectorant- Demulcent	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN [®]	●					●
ROBITUSSIN A-C [®]	●	●	●			
ROBITUSSIN-DM [®]	●	●		●		●
ROBITUSSIN-PE [®]	●				●	●
COUGH CALMERS [®]	■	■		■		■

Use this handy chart as a guide in selecting the formula that provides the benefits you want for your patient.

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

ROBITUSSIN[®]

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs

ROBITUSSIN A-C[®]

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM[®]

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide 15 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS[®]

Each Cough Calmer contains:

Glyceryl guaiacolate 50 mg.
Dextromethorphan hydrobromide 7.5 mg.

Relieves cough, clears sinuses and nasal passages—
keeps them "drip-dry" but not bone dry

ROBITUSSIN-PE[®]

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride 10 mg.
Alcohol, 1.4%

A·H·ROBINS

A. H. Robins Company, Richmond, Virginia 23220

The Willing Worker



Intense spasm of the descending colon seen in a 55-year-old female with symptomatology consistent with the irritable bowel syndrome.

with an unwilling colon

A diagnosis of irritable bowel syndrome has not changed her temperament one iota. She still suffers exacerbations of the condition whenever she experiences excessive anxiety that is added to increased responsibility. Yet she continues to accept more responsibilities that require more time and energy and build up more anxiety and tension.

The need to reduce G.I. hypermotility and undue anxiety

The need to reduce G.I. hypermotility is apparent in treating the irritable bowel syndrome. But overanxiety is often perceived as one of the related factors which can contribute to an abnormal increase in motor activity in the colon. When both factors are present, Librax may be a valuable adjunct in therapy.

The dual nature of Librax

As an adjunct to a therapeutic regimen, Librax may help relieve the undue anxiety and associated somatic factors that can contribute to the exacerbation of irritable bowel syndrome. Only Librax combines in one capsule the dependable antispasmodic action of Quarzan® (clidinium Br) and the well-known antianxiety action of Librium® (chlordiazepoxide HCl).

Up to 8 capsules daily in divided doses

According to individual requirements, 1 or 2 capsules, 3 or 4 times daily.

Rx: Librax #35 for initial evaluation of patient response to therapy.

Rx: Librax #100 for follow-up therapy—this prescription for 2 to 3 weeks' medication can help maintain patient gains while permitting less frequent visits.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

For the anxiety-linked symptoms of irritable bowel syndrome

adjunctive
Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Clinics for Crippled Children Listed for November

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Nov. 1 Lake County Cardiac—Victory Memorial Hospital
- Nov. 1 Sterling—Sterling Community Hospital
- Nov. 1 Effingham—St. Anthony Memorial Hospital
- Nov. 1 Pittsfield—Illini Hospital
- Nov. 1 West Frankfort—Union Hospital
- Nov. 5 Peoria Cardiac—St. Francis Children's Hospital
- Nov. 6 Belleville—St. Elizabeth's Hospital
- Nov. 6 Fairfield—Fairfield Memorial Hospital
- Nov. 7 Hinsdale—Hinsdale Sanitarium
- Nov. 8 Macomb—McDonough District Hospital
- Nov. 8 Springfield—St. John's Hospital
- Nov. 9 Chicago Heights Cardiac—St. James Hospital
- Nov. 13 Peoria—St. Francis Children's Hospital
- Nov. 13 East St. Louis—Christian Welfare Hospital
- Nov. 14 Joliet—St. Joseph's Hospital
- Nov. 14 Champaign-Urbana—McKinley Hospital
- Nov. 14 Springfield Pediatric-Neurological—Diocesan Center
- Nov. 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Nov. 15 Decatur—Decatur Memorial Hospital
- Nov. 15 DuQuoin—First Methodist Church
- Nov. 20 Rock Island—Moline Public Hospital
- Nov. 21 Evergreen Park—Little Company of Mary Hospital
- Nov. 26 Peoria Cardiac—St. Francis Children's Hospital
- Nov. 27 Peoria—St. Francis Children's Hospital
- Nov. 27 Alton—Alton Memorial Hospital
- Nov. 28 Elgin—Sherman Hospital
- Nov. 28 Centralia—St. Mary's Hospital
- Nov. 28 Rockford—St. Anthony's Hospital
- Nov. 30 Chicago Heights Cardiac—St. James Hospital

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. $\frac{1}{4}$ grain; $\frac{1}{2}$ grain; scored 1 grain; $1\frac{1}{2}$ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?

Unlike U.S.P.
desiccated thyroid,
Proloid® (thyro-
globulin) offers
the assurance of
constant potency.

To begin with,
Proloid is uniquely
purified. The

thyroglobulin extracted from hog thyroid is devoid of any glandular debris.

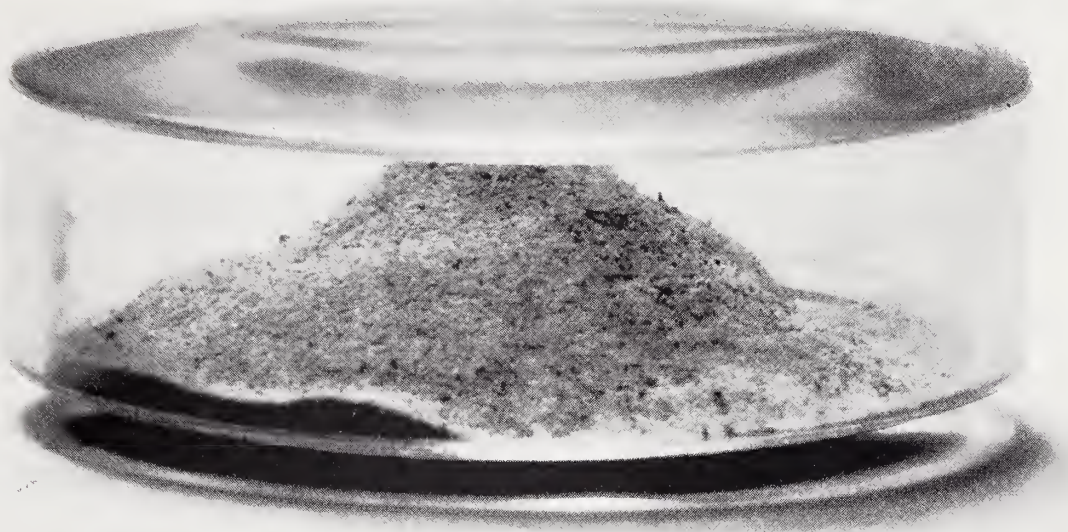
Then, Proloid is chemically and biologically assayed to assure consistent
metabolic activity from batch to batch. The T_4 and T_3 content of every dose is
blended for optimal thyroid replacement.

Important, too, is the fact that Proloid is invariably "fresh" when your patients
take it. Under proper storage conditions, its potency will not diminish for at least
four years.

All of which adds up to this: the potency of Proloid is constant...for more
consistent results.

PROLOID® **(thyroglobulin)**

natural thyroid therapy
that leaves
nothing to chance



Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

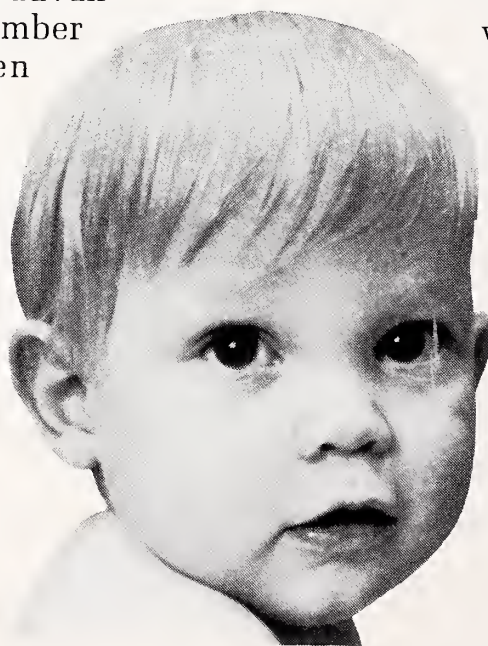
[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R^{*}

(MEASLES, MUMPS AND RUBELLA
VIRUS VACCINE, LIVE | MSD)

Single-dose vials

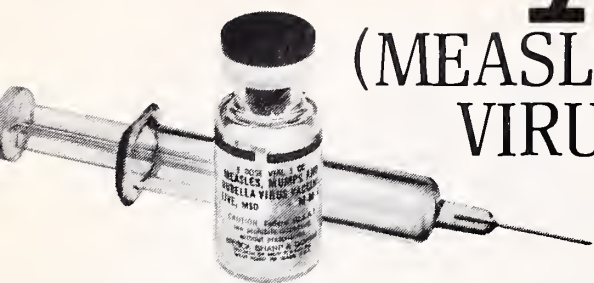
M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

^{*}Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.



M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

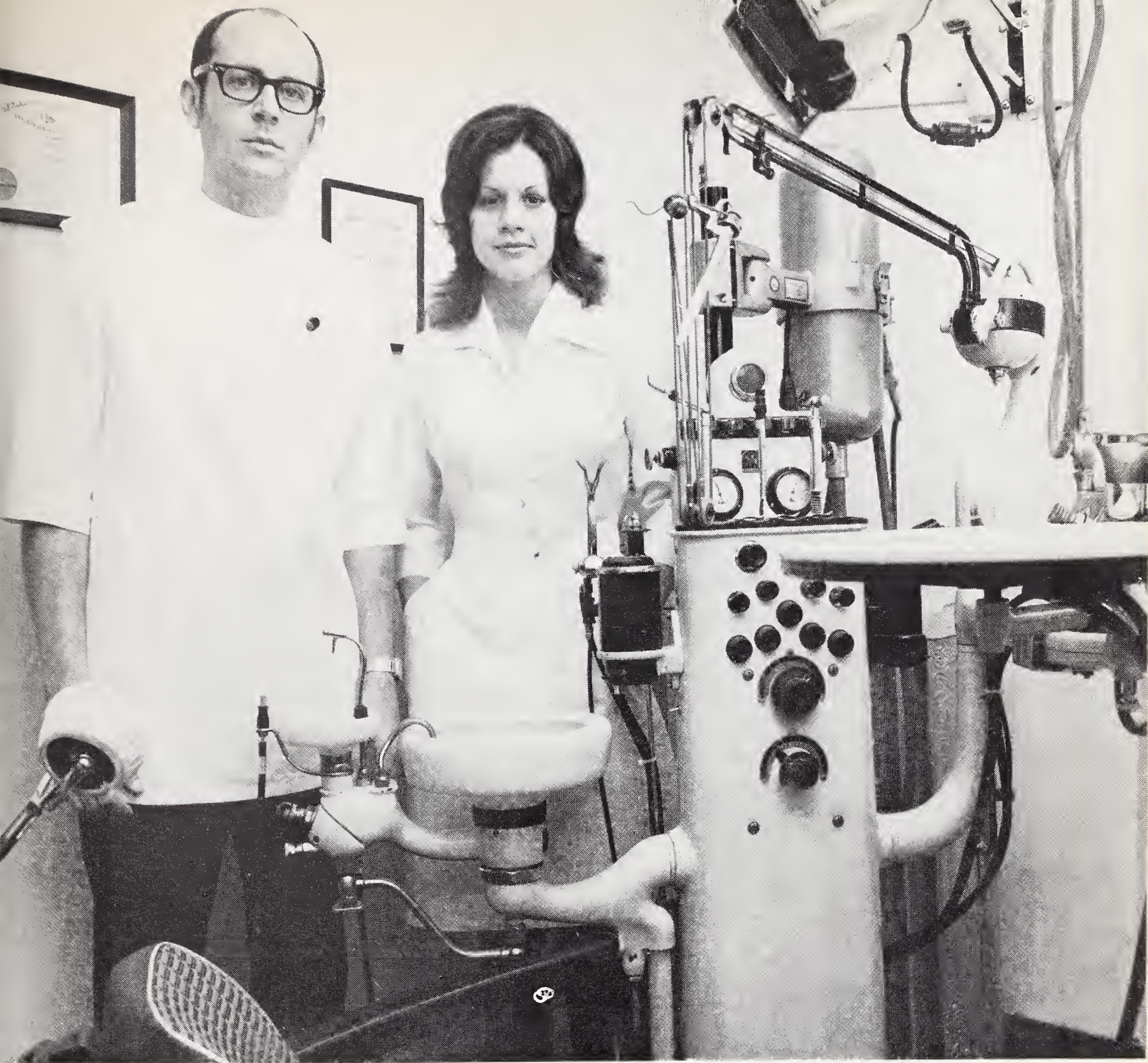
Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

MSD
MERCK
SHARP &
DOHME



Even a small corporation needs a profit sharing plan.

Maybe you can count the people in your corporation on one jaw. But even if your business isn't big, you can still set up a money-making profit sharing plan. Our *Master Profit Sharing Plan* makes it easy.

Do you know why more and more incorporated professionals use profit sharing? First, it's a tax shelter for your income. You can put up to 15% of payroll in the plan. Second, professional money managers keep your money invested, so your profits produce more profits. Nobody can guarantee what rate of return you'll get. But here are the amounts you could

receive if you put aside just \$1,000 per year for 25 years:

Rate of Return (Compounded Annually)	Total in 25 years
8%	\$73,106
6%	54,865
4%	41,646

When you adopt our Master Profit Sharing Plan nearly two dozen of Chicago's best qualified money managers watch over your investments. They're backed up by thorough economic analysis, market research and eighty five years of profitable history in assets management. We handle all the details too. The paperwork, rec-

ords, government forms and approvals are all taken care of.

It doesn't matter whether your corporation has three employees or 3,000. Your profits could work harder for you and your future in Chicago Title and Trust's Master Profit Sharing Plan. For a free booklet describing this plan, just call Jack Osgood at 332-7700.

Chicago Title and Trust Company

111 West Washington Street, Chicago, Illinois 60602
Member of the Lincoln National family of corporations

In Gonorrhea

Injection **WYCILLIN®**
(sterile procaine penicillin G
suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae*: acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity.

Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by deep intramuscular injection, in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated) — Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae*. Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages.

And destroy another link in the chain of infection.

In Syphilis

Injection

BICILLIN® Long-Acting
(sterile benzathine penicillin G
suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If

allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisypilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

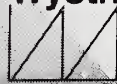
Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by deep intramuscular injection in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories • Philadelphia, Pa. 19101





Placidyl® (ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated for short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients for possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, blurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited in elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also act in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient dizziness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction complicated by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia often accompanies a cardiovascular episode. How many nights does he lie awake, awaiting exactly what he fears most . . . another stroke, another heart attack? He doesn't need fear. He needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl®



(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





No Time For Weakness

We often think of organized medicine as a powerful and effective force. Unfortunately, we sometimes overlook the fact that this complex organizational structure is no stronger than its county medical societies.

We must have strong leadership in our county societies, right now, and in the years ahead, to meet the multitude of challenges facing our profession.

The county medical society always has been considered the fundamental group in organized medicine. It is the grass roots unit and the physician's spokesman, the basic organization through which effective programs can be mounted and activities initiated in behalf of all physicians in the area.

Changes in the state's political, social and economic climate make it essential for us to review the purposes and functions of our county societies, and to re-evaluate their roles. Hopefully, this will result in a wider understanding among physicians of the need to support their county societies.

We are all aware that the changes within medicine and its environment have been numerous and massive. Scientific knowledge is mushrooming; financing mechanisms for medical care are more complex; the role of third parties, including government, is growing; legislation has been passed with considerable impact on health care, and Congress and the General Assembly can be expected to approve even more such legislation.

There is also a growing desire for more lay participation in health care, which requires a continuing dialog between the public and our profession, and more leadership from physicians.

Thousands of other professionals and technicians are working with Illinois physicians in health care, and liaison and guidance are needed from us to define responsibilities and clarify overall working relationships.

These and other developments are indications that medicine is of ever-increasing importance. It is in the interest of our profession and the public that we offer assistance and leadership. And the most effective way a physician can do this is to become involved in the activities of his county medical society.

Through this local unit, he can assist his peers

with the planning and implementation of projects on the state, district and national levels.

We live in an age of strife, struggle and change. And medicine is changing, in part because of explosive progress in the science of medicine, and in part because of socioeconomic forces outside medicine.

Certain forces seek to control the practice of medicine, and to alter its structure. We cannot ignore them. We cannot merely increase our knowledge, improve our skill and be good doctors, hoping that somehow we can escape the consequences of the floodtide of change.

We must *PARTICIPATE* if we are to fulfill our role!

That role is aggressive, responsible and constructive leadership in our health care system. It is up to us to shape the manner in which health care will be delivered to the people of Illinois, and to assure that the quality of care will not be eroded.

We must have effective leaders at all levels of medical organization. We need positive ideas, constructive action, effective and courageous leadership to solve the problems of health manpower, rising costs and productive allocation of health care resources and facilities.

The place to begin solving these problems—the place to begin plans, programs and activities—is the level of the county medical society.

We cannot ignore the social and ideological struggle of our times. The question is, do we want to lead or follow? We all know the answer to that.

I urge you to be a part of the action; to be a voice in the vital decisions that must be made, and to be a leader.

With the help of each of you, we can make medicine a stronger influence upon the affairs of this state, and we can meet the health care needs of the people of Illinois.

If any county society, or any other medical organization, isolates itself from the rest of medicine, the entire effort of our profession will be weakened.

And this is no time for weakness.

William E. Schuman M.D.

Unity + Strength = Effectiveness

What the Sleep Research Laboratory recorded about DALMANE[®] sleep...¹

(flurazepam HCl)

- reduced sleep latency
- decreased time awake after sleep onset
- increased total sleep time

The polygraphic techniques of the sleep research laboratory have objectively documented the value of Dalmane (flurazepam HCl) for patients with difficulty falling asleep or staying asleep.

Hundreds of hours of monitored sleep¹⁻⁹ have shown that one 30-mg capsule of Dalmane at bedtime generally induced sleep within 17 minutes, significantly reduced time awake after sleep onset and provided 7 to 8 hours of sleep. Dalmane effectiveness was maintained even over 14 consecutive nights of administration, demonstrating the consistent effectiveness of Dalmane.

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though

physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude over-sedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were

headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.





What the patients reported when they awoke¹

- ☐ more rapid sleep induction
- ☐ increased duration of sleep

The utility of any sleep medication depends, ultimately, on patient acceptance. For this reason, sleep laboratories evaluating Dalmane (flurazepam HCl) have obtained the patients' own estimates of their sleep immediately on awakening in the morning. These subjective evaluations have been in strong agreement with the polygraphic records, confirming polygraphic evidence of Dalmane effectiveness compared to placebo.

Morning "hang-over" with Dalmane has been relatively infrequent. In most instances, adverse reactions, when reported, were mild and infrequent. Dizziness, drowsiness, lightheadedness and the like have been side effects noted most often, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule h.s.—usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule h.s.—initial dosage for elderly or debilitated patients.



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Loridine® I.M. cephaloridine

500-mg. and
1-Gm. ampoules



*Additional information available
to the profession on request.*

Eli Lilly and Company • Indianapolis, Indiana 46206

300121



REFRESH



I M J

Illinois Medical Journal

Vol. 144, No. 4, October, 1973

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Constitution And Bylaws

March 1973

Adopted, 1903
As Amended, 1973

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Provisional members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

B. *Provisional Members.* Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member

could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.

D. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years, have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application to their component society and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

E. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

F. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership. Physicians serving as full-time employees at the headquarters of the American Medical Association shall be eligible for service membership following approval and recommendation by their component medical society. Membership in this classification shall terminate on cessation of active duty.

G. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

H. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois. They must be recommended for membership by two members of this Society who are also members of the hospital staff where the candidate is in training. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

I. *Student Members.* Student members are those who have been accepted for the second year or higher in an Illinois medical school, are members of the Student American Medical Association, are of good moral character, professional and academic standing and student members of a component medical society where provision has been made for this class of membership. Membership shall terminate upon graduation.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension, or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year shall be grounds for termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Provisional, Associate, In-training and Student members shall be assessed annual dues. The dues shall be paid by the component society for its members prior to May 1 of each year.

Section 2. *Reduction and Remission of Dues.* The Board of Trustees upon recommendation of the component society, shall give fifty percent reduction in dues to teaching, research and administrative personnel in full-time employment in the approved medical schools in Illinois, or in similar not-for-profit institutions in Illinois. Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members on

recommendation of the Board of Trustees and approval of the House of Delegates. Funds may be raised from publications of the Society and any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to be spent for the Society to carry on its publications, to encourage scientific investigations, and for other purposes approved by the Board of Trustees.

CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies and affiliated groups, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association may have the privilege of the floor without vote.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year, for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group and shall be entitled to one student delegate with vote, and one student alternate delegate to serve in the House of Delegates. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet annually at such time and place as it shall determine.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the sec-

retary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturges Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice

presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-president, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, or resignation of the speaker, the

vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: nineteen trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary treasurer. Nine trustees shall be chosen from District 3 and one from each of the other ten districts as defined on the geographical map of the state approved in May, 1946.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific

investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide

at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio members of all district committees. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural

rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter XI of these Bylaws)

Section 2. *Councils.*

- A. The Medical-Legal Council shall be concerned in the areas of:
 - 1. Liaison with the Illinois Bar Association
 - 2. Liaison with courts, particularly where impartial medical testimony is involved.
 - 3. Implementation of the Impartial Medical Testimony Rule
 - 4. Legal aspects of medical practice other than in the area of mental health
 - 5. Licensing and standards of practice.
 - 6. Quackery
 - 7. Anatomical gifts and organ transplants
- B. The Council on Governmental Affairs shall be concerned in the areas of:
 - 1. Federal and state legislation—analysis and communication
 - 2. Legislative liaison—both state and federal
 - 3. Political education
- C. The Council on Education and Manpower shall be concerned in the areas of:
 - 1. Liaison with medical schools, curricula, etc.
 - 2. Health manpower and training
 - 3. Internships, residencies, etc.
 - 4. Scientific assembly
 - 5. Student loans
 - 6. Liaison with Student American Medical Association
 - 7. Continuing Medical Education
- D. The Council on Economics and Peer Review shall be concerned in the areas of:
 - 1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)

- 2. Relations with prepayment, insurance and other third party plans.
 - 3. Fees and fee adjudication
 - 4. Health care cost and utilization
 - 5. Peer Review (Part 2 of Chapter XII of these Bylaws)
- E. The Council on Environmental and Community Health shall be concerned in the areas of:
 - 1. Governmental Departments of Health
 - 2. Public Safety
 - 3. Occupational Health
 - 4. Child and School Health
 - 5. Pollution
 - 6. Nutrition
 - 7. Maternal Welfare
- F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 - 1. Publicity and promotion
 - 2. News media relations
 - 3. Exhibits and public service programming
 - 4. Religion and medicine
 - 5. New member orientation and membership benefit explanation
- G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 - 1. Facilities and services
 - 2. Liaison with Department of Mental Health
 - 3. Legal aspects of commitment, etc.
 - 4. Narcotics and dangerous drugs
 - 5. Alcoholism
- H. The Council on Social and Medical Services shall be concerned in the areas of:
 - 1. Health care facilities and services
 - 2. Emergency and disaster care
 - 3. Liaison with other health professional and health oriented organizations
 - 4. Health care of the poor
 - 5. Problems of aging
 - 6. Rural health
- I. The Council on Affiliate Societies shall be concerned in the areas of:
 - 1. Liaison between the affiliate society and ISMS.
 - 2. Scientific resource information and advice to ISMS.
 - 3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
 - 4. Advances of medical science in special fields.

Section 3. *Organization of Councils.*

- A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
- B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or pur-

poses assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommit-

tees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois

a) as may be approved by the Board of Trustees

b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.

2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.

3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

- F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

- A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of trustees shall form the following committees within itself:

- A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee.

The Board of Trustees may delegate to the executive committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the

Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

- C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

- D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

- E. The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

- F. The Committee on Constitution and Bylaws shall consist of five members of the Board appointed by the chairman and it shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

- G. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish

format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. The Advisory Committee to the Woman's Auxiliary shall consist of the president-elect as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not

had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this society no later than 120 days prior to annual meeting.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association

ciation, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
 1. of a gross misconduct as a physician, or
 2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. An accused is presumed to be innocent until he has been proven guilty.
- B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.
- C. A trial shall be held by the committee within 30 days

after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the trial, together with a statement of the rights of the accused as follows:

1. to be represented by any member of the society as counsel and that he may have legal counsel present;
2. to cross-examine witnesses;
3. to offer in evidence any pertinent records or documents;
4. to object to any testimony or exhibits offered in evidence;
5. to address the trial body in his own behalf;
6. to be tried only on the specific charges filed;
7. to have stricken from the record any improper testimony or exhibits;
8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused not guilty.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county

society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII. PEER REVIEW

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate.

Section 2. The council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or

Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these

Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

Index to Constitution and Bylaws

Ad hoc Committees311

Advisory Committee to Woman's Auxiliary313

Affiliate Societies

 Council on310

 organization311

Amendments

 to the Bylaws316

 to the Constitution305

American Medical Association

 election of Illinois Delegates, alternates308

 membership305

Annual Dues, Assessments306

Audit and Financial Statement309

Benevolence Fund309

Board of Trustees

 committees312

 composition307

 election by House of Delegates313

 election of Chairman309

 duties308

 meetings309

 organization309

 powers313

 quorum309

 term of office313

 vacancies309

Banding of officers and employees309

Bylaws305

Changes in Constitution and Bylaws Committee311

Committee on Committees312

Composition308

 procedure314

Composition of the Society305

Constitution and Bylaws, Committee on311

Conventions and Meetings305

 Education and Scientific Programs307

 House of Delegates307

Councils (standing committees)

 duties310

 organization of310

 reports311

 terms of office311

 vacancies311

County Societies, Organization of313

Credentials Committee311

Discipline

 Component Society Procedure314

 State Medical Society Procedure314

District Committees309

Economics and Peer Review, Council on310

Education and Manpower, Council on310

Educational and Scientific Programs307

 date of307

 meeting place307

Environmental and Community Health, Council on310

Ethical Relations Committee314

Executive Administrator309

Executive Committee312

Finance and Medical Benevolence Committee313

Governmental Affairs, Council on310

House of Delegates

 composition307

 delegates307

 district divisions307

 elections308

 meetings307

 order of procedure307

 term of office308

House of Delegates Committee311

 duties311

 elections308

 organization312

Membership

 associate members306

 discrimination of membership306

 distinguished members306

 emeritus members306

 in-training members306

 provisional members305

 regular members305

 retired members306

 service members306

 student members306

 tenure and termination of membership306

Officers

 elections308

 duties308

 terms of office308

Medical-Legal, Council on310

Mental Health and Addiction, Council on310

Miscellaneous316

Parliamentary Procedures316

Peer Review

 Component Society Procedures315

 State Medical Society Procedure315

Policy Committee312

Publication Committee312

Publication Relations and Membership Services, Council on310

Reference Committees311

Rules and Order of Business Committee311

Seal, the305

Social and Medical Services, Council on310

Tellers and Sergeants-at-arms Committee311

Woman's Auxiliary, Advisory Committee to313

1973-1974 Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in **ARTICLE V:**

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

Alcoholism

Since alcoholism has been widely regarded as a disease for some time and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions.

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their

communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital-Medical Staff-Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Insurance Plans for Patients

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be

urged to select a physician.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and populations districts to achieve program efficiency.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

ADMINISTRATIVE POLICIES

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Autonomy of County Medical Services

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is

scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy

- establish new policy

- request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of,

or in opposition to, the legislation recommended by the Council or Committee.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of

Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion has been expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the prin-

ciple of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

APPENDIX

Multiphasic Health Testing Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Use of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources,

following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise.

He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians should be involved in the planning and development of testing programs, and the operation of all programs should be supervised by qualified physicians.
4. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
5. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.

6. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
7. The program should provide for confidentiality of patient data.
8. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
9. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
10. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
11. The program should maintain freedom of choice for both the physician and the patient.

AMA DELEGATION

Delegates to the American Medical Association

To Serve From Jan. 1, 1972 to Dec. 31, 1973
(elected May 19, 1971)

Jack Gibbs
175 South Main St., Canton 61520
Theodore Grevas
1800 Third Ave., Rock Island 61201
Morgan M. Meyer
573 South Lombard, Lombard 60148
Edward A. Piszczek
6410 North Leona, Chicago 60646
Harold A. Sofield
715 Lake St., Oak Park 60301
Philip G. Thomsen
13826 Lincoln, Dolton 60419

To Serve From Jan. 1, 1973 to Dec. 31, 1974
(elected March 10, 1972)

Carl E. Clark
225 Edward St., Sycamore 60178
H. Close Hesselstine
5807 South Dorchester, Chicago 60637
Maurice M. Hoeltgen
1836 West 87th St., Chicago 60620
William M. Lees¹
6518 North Nokomis, Lincolnwood 60646
Joseph R. Mallory²
Linck Clinic, Mattoon 61938
Theodore R. Van Dellen
435 North Michigan Ave., Chicago 60611
Charles K. Wells³
117 North 10th St., Mt. Vernon 62864

To Serve From Jan. 1, 1974 to Dec. 31, 1975
(elected March 28, 1973)

Jack Gibbs
175 South Main St., Canton 61520
Theodore Grevas
1800 Third Ave., Rock Island 61201
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
William M. Lees¹
6518 North Nokomis, Lincolnwood 60646
Morgan M. Meyer
573 South Lombard, Lombard 60148
Edward A. Piszczek
6410 North Leona, Chicago 60646
Philip G. Thomsen
13826 Lincoln, Dolton 60419

¹Elected to newly created 12th Delegate position March 28, 1973, effective March 28, 1973 to December 31, 1974. (He was serving as Alternate Delegate January 1, 1972-December 31, 1973.)

²Resigned, effective March 28, 1973.

³Elected March 28, 1973, to fill unexpired term (Jan. 1, 1973-Dec. 31, 1974) of Joseph R. Mallory, resigned.

Honorary Delegates

Walter C. Bornemeier
19273 Harleigh Dr., Sargato, Calif. 95070
Edwin S. Hamilton
985 Cobb Street, Kankakee 60901
George F. Lull
2440 Lakeview Avenue, Chicago 60614
Burtis E. Montgomery
37 South Main Street, Harrisburg 62946

Alternate Delegates to the American Medical Association

To Serve From Jan. 1, 1972 to Dec. 31, 1973
(elected May 19, 1971)

Herschel Browns
4600 North Ravenswood Ave., Chicago 60640
William M. Lees^a
6518 North Nokomis, Lincolnwood 60646
George C. Shropshire
1525 East 53rd St., Chicago 60615
Paul W. Sunderland
214 North Sangamon, Gibson City 60936
Glen Tomlinson
1825 West Harrison St., Chicago 60612
Charles K. Wells^b
117 North 10th St., Mt. Vernon 62864

To Serve From Jan. 1, 1973 to Dec. 31, 1974
(elected March 10, 1972)

Alfred J. Faber
2110 Swainwood Dr., Glenview 60025
Frank J. Jirka, Jr.^c
1507 Keystone Ave., River Forest 60305
Eugene T. Leonard
1215 North Alpine, Rockford 61107
John Ring
511 East Hawley St., Mundelein 60060
Fred A. Tworoger
4753 Broadway, Chicago 60640

To Serve From Jan. 1, 1974 to Dec. 31, 1975
(elected March 28, 1973)

Herschel Browns
4600 North Ravenswood Ave., Chicago 60640

Allison L. Burdick, Jr.^d
10 West Ontario, Oak Park 60302
Jerry M. Ingalls^e
Medical Center, Paris 61944
Fredric D. Lake
2520 North Lakeview, Chicago 60614
Joseph R. O'Donnell^f
444 Park Ave., Glen Ellyn 60137
George Shropshire
1525 East 53rd St., Chicago 60615
Paul W. Sunderland
214 North Sangamon, Gibson City 60936
Glen Tomlinson
1825 West Harrison St., Chicago 60612

^aElected to position of 12th Delegate March 28, 1973, effective March 28, 1973.

^bElected to Delegate position, March 28, 1973 effective March 28, 1973, to fill unexpired term of Joseph R. Mallory who resigned.

^cElected to Delegate position March 28, 1973, effective Jan. 1, 1974.

^dElected March 28, 1973, to fill unexpired portion of term (Jan. 1, 1972-Dec. 31, 1973) of William M. Lees (elected new 12th Delegate) and for Jan. 1, 1974-Dec. 31, 1975.

^eElected March 28, 1973, to fill unexpired portion of term (Jan. 1, 1972-Dec. 31, 1973) of Charles K. Wells (elected Delegate) and for Jan. 1, 1974-Dec. 31, 1975.

^fElected March 28, 1973, to fill position of 12th Alternate Delegate created in 1973.

ISMS House of Delegates

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—Willard C. Scrivner
Suite 2, 6600 W. Main, Belleville 62223
President-elect—Fredric D. Lake
1041 Michigan Ave., Evanston 60202
Secretary-Treasurer—Jacob E. Reisch
1229 S. 2nd St., Springfield 62704
First Vice-President—Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
Second Vice-President—Charles J. Weigel
7579 Lake Street, River Forest 60305
Speaker of the House—Andrew J. Brislen
6060 S. Drexel Blvd., Chicago 60637
Vice-Speaker of the House—James A. McDonald
13 S. 2nd St., Geneva 60134

Board of Trustees

Chairman, Board of Trustees—William M. Lees1974
6518 N. Nokomis, Lincolnwood 60646
1st District—Joseph L. Bordenave1974
1665 South St., Geneva 60134
2nd District—Allan L. Goslin1976
712 N. Bloomington, Streator 61364
3rd District—David S. Fox1976
20829 Green Center Court,
Olympia Fields 60461
Robert T. Fox1976
2136 Robin Crest Lane, Glenview 60025
Eugene T. Hoban1975
6429 North Ave., Oak Park 60302
Joseph Skom1975
707 Fairbanks, Chicago 60611

William M. Lees1974
6518 N. Nokomis, Lincolnwood 60646
George C. Shropshire1974
1525 E. 53rd, Chicago 60615
Philip G. Thomsen1974
13826 Lincoln, Dolton 60419
Frederick E. Weiss1976
15643 Lincoln, Harvey 60426
Warren W. Young1975
3450 Haweswood Dr., Crete 60417
4th District—Fred Z. White1976
723 N. 2nd St., Chillicothe 61523
5th District—A. Edward Livingston1976
219 N. Main, Bloomington 61701
6th District—Mather Pfeifferberger1975
State & Wall Streets, Alton 62002
7th District—Arthur F. Goodyear1976
142 E. Prairie Ave., Decatur 62523
8th District—Eugene P. Johnson1976
P.O. Box 68, Casey, 62420
9th District—Warren D. Tuttle1975
203 N. Vine, Harrisburg 62946
10th District—Herbert Dexheimer1975
301 S. Illinois, Belleville 62220
11th District—Joseph R. O'Donnell1974
444 Park, Glen Ellyn 60137
Trustee at Large—Frank J. Jirka, Jr.1974
1507 Keystone, River Forest 60305

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House will appear with the convention program.

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

J. Ernest Breed1971
Everett P. Coleman1945-1946
Edward W. Cannady1970
Newton DuPuy1968
Harlan English1964
Edwin S. Hamilton1962
H. Close Hesseltine1961
Charles J. Jannings, III1972
Frank J. Jirka, Jr.1973
Willis I. Lewis1954
George F. Lull1963
Burtis E. Montgomery1966
Edward A. Piszczek1965
Caesar Portes1967
Leo P. A. Sweeney1953
Philip G. Thomsen1969
Arkell M. Vaughn1955

Past Trustees

William E. Adams
Chicago, Trustee of the 3rd District
Earl H. Blair
Chicago, Trustee of the 3rd District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Carl E. Clark
Sycamore, Trustee of the 1st District

Willard W. Fullerton
Sparta, Trustee of the 10th District
George E. Griffin
Princeton, Trustee of the 2nd District
Lee N. Hamm
Lincoln, Trustee of the 5th District
George A. Hellmuth
Chicago, Trustee of the 3rd District
Bernard Klein
Joliet, Trustee of the 11th District
Ted LeBoy
Chicago, Trustee of the 3rd District
Warner H. Newcomb
Jacksonville, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee from the 2nd District
Paul P. Youngberg
Moline, Trustee of the 4th District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
William H. Schowengerdt
Champaign, Trustee of the 8th District
Charles K. Wells
Mt. Vernon, Trustee of the 9th District

Past Speakers

Walter C. Bornemeier, Chicago1961-1964
Edward W. Cannady, Belleville1964-1967
Maurice M. Hoeltgen, Chicago1967-1970
Paul W. Sunderland, Gibson City1970-1973

Officers of County Medical Societies

1973

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 85-Dist. No. 6	Richard E. Meyer 1400 Maine, Quincy 62301	Julio del Castillo Ill. St. Bank Bldg., Quincy 62301
ALEXANDER Members: 6-Dist. No. 10	Gemo Wong 1201 Washington, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 8-Dist. No. 7	James R. Goggin 207 N. 2nd St., Greenville 62246	Kenneth Kaufman 105 E. College, Greenville 62246
BOONE Members: 14-Dist. No. 1	Richard Yee 1023 Logan, Belvidere 61108	Earl S. Davis 119 S. State, Belvidere 61108
BUREAU Members: 23-Dist. No. 2	Kent McQueen Tiskilwa 61368	Karl D. Nelson 101 Park, Princeton 61356
CARROLL Members: 8-Dist. No. 1	C. G. Piper 203 W. Market, Mt. Carroll 61053	Eliseo M. Colli 102 Washington, Mt. Carroll 61053
CASS-BROWN Members: 6-Dist. No. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	A. G. Hyde 507 Washington, Beardstown 62618
CHAMPAIGN Members: 205-Dist. No. 8	Harold J. Kolb St. Joseph 61873	H. Ewing Wachter 1609 W. Springfield, Champaign 61820
CHRISTIAN Members: 20-Dist. No. 7	P. K. Hagen 311 S. Main, Taylorville 62568	J. W. Murphy 301 S. Webster, Taylorville 62568
CLARK Members: 5-Dist. No. 8	Eugene P. Johnson P.O. Box 68, Casey 62420	Charles G. Moore, Jr. Martinsville Clinic, Martinsville 62442
CLAY Members: 7-Dist. No. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
CLINTON Members: 12-Dist. No. 7	M. B. Floreza 118 North Oak, Trenton 62293	F. H. Ketterer 289 N. Main St., Breese 62230
COLES-CUMBERLAND Members: 39-Dist. No. 8	Ray A. Dougherty Link Clinic, Mattoon 61938	Jerry D. Heath 6 Orchard Drive, Charleston 61920
CRAWFORD Members: 14-Dist. No. 8	Herbert F. Iknayan 408 So. Cross, Robinson 62454	W. B. Schmidt 408 So. Cross, Robinson 62454
DE KALB Members: 52-Dist. No. 1	Stuart K. Olson 232 So. 2nd St., De Kalb 60115	William Deschler 225 Edwards, Sycamore 60178
DE WITT Members: 9-Dist. No. 5	John W. Viers 219 E. Main, Clinton 61727	Charles A. Ramey 215 E. Main, Clinton 61727
DOUGLAS Members: 9-Dist. No. 8	Humberto Mondul 100 N. Main, Tuscola 61953	Elmer S. Allen 120 S. Locust, Arcola 61910
DU PAGE Members: 440-Dist. No. 11 Lillian Widmer, Exec. Sec. 646 Roosevelt Rd. Glen Ellyn 60137	Charles G. White Naperville Plaza, Naperville 60540	James P. Campbell 322 N. Blanchard, Wheaton 60187
EDGAR Members: 16-Dist. No. 8	Joseph R. Shackelford Medical Center Clinic, Paris 61944	J. M. Ingalls 502 Shaw, Paris 61944
EDWARDS Members: 2-Dist. No. 9	Paul S. Neirenberg 7 W. Main, Albion 62806	Andrew Krajec Box 336, West Salem 62476
EFFINGHAM Members: 20-Dist. No. 7	Frederick M. Reis 503 N. Maple, Effingham 62401	H. E. Morales 300 N. Maple, Effingham 62401

COUNTY	PRESIDENT	SECRETARY
FAYETTE Members: 9-Dist. No. 7	D. H. Rames Vandalia 62471	E. A. Kuehn 501 W. Gallatin, Vandalia 62471
FORD Members: 10-Dist. No. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 21-Dist. No. 9	Loren L. Love 6 Hillcrest Dr., Christopher 62822	D. P. Richerson P.O. Box 99, Christopher 62822
FULTON Members: 26-Dist. No. 4	Raoul Reinertsen Coleman Clinic, Canton 61520	Marvin E. Schmidt Graham Hospital, Canton 61520
GALLATIN Members: 2-Dist. No. 9	Wilbur Stanelle Shawneetown 62984	John E. Doyle Ridgway 62979
GREENE Members: 6-Dist. No. 6	Gary L. Turpin 712 S. College, Greenfield 62044	James C. Reid Fillager Mem. Clinic, Greenfield 62044
HANCOCK Members: 10-Dist. No. 4	Ilse Bruchsel 325 Polk, Warsaw 62379	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 1-Dist. No. 4		Silvino Lindo, Jr. Biggsville 61448
HENRY-STARK Members: 29-Dist. No. 4	Andrew E. Skladany 1202 Fourth St., Orion 61273	
IROQUOIS Members: 17-Dist. No. 11	D. R. Cozad Clifton 60927	Dale Learned 219 N. Central, Gilman 60938
JACKSON Members: 50-Dist. No. 10	Raimundo M. Rodriguez 106 So. 14th St., Murphysboro 62966	Sidney G. Smith P.O. Box 2347, Carbondale 62901
JASPER Members: 2-Dist. No. 8	Don L. Hartrich Box 192, Newton 62448	Monico Low P.O. Box 188, Newton 62448
JEFFERSON-HAMILTON Members: 36-Dist. No. 9	James R. Heersma 117 N. 10th St., Mt. Vernon 62864	Antonio Boba #1 Doctors Pk. Rd., Mt. Vernon 62864
JERSEY-CALHOUN Members: 10-Dist. No. 6	Bernard Baalman Medical Center, Hardin 62047	Larry Plummer 306 S. Washington, Jerseyville 62052
JO DAVIESS Members: 9-Dist. No. 1	Wilbur E. Johnson Galena 61036	Lyle A. Rachuy 323 N. Main St., Stockton 61085
JOHNSON Members: 1-Dist. No. 9		
KANE Members: 273-Dist. No. 1 Michael Wild, Exec. Dir. 214 W. State St. Geneva 60134	George A. Wiltrakis 606 So. Riverside, St. Charles 60174	Emanuel M. Herzon 860 Summit St., Elgin 60120
KANKAKEE Members: 92-Dist. No. 11	T. P. Hickey 555 So. Schuyler, Kankakee 60901	A. A. Palow 555 So. Schuyler, Kankakee 60901
KENDALL Members: 8-Dist. No. 11	Joseph L. Daw Oswego Medical Group, Oswego 60543	Suzanne M. Roscoe Oswego Medical Group, Oswego 60543
KNOX Members: 59-Dist. No. 4	Robert Reed Bondi Bldg., Galesburg 61401	Juan Espejo 674 N. Seminary, Galesburg 61401
LAKE Members: 266-Dist. No. 1 Mrs. Julia Schulz Exec. Sec., P.O. Box 148 Gurnee 60031	Charles U. Culmer P.O. Box 548, Libertyville 60048	Edward May 3895 Grand, Gurnee 60031
LA SALLE Members: 91-Dist. No. 2	Robert Duncan La Salle 61301	Allan L. Goslin 712 N. Bloomington, Streator 61364

COUNTY	PRESIDENT	SECRETARY
LAWRENCE Members: 8-Dist. No. 8 Ruth Gariepy, Exec. Sec. Lawrence City Mem. Hosp. Lawrenceville 62439	R. T. Kirkwood Kensler Bldg., Lawrenceville 62439	Larry D. Herron N. Main St., Bridgeport 62417
LEE Members: 22-Dist. No. 2	Wayne Spenader Amboy 61310	William McNichols 101 W. 1st St., Dixon 61021
LIVINGSTON Members: 31-Dist. No. 2	Floyd Weaver Bank of Pontiac Bldg., Pontiac 61764	Karl T. Deterding 612 E. Water St., Pontiac 61764
LOGAN Members: 21-Dist. No. 5	H. R. Rivero 914 E. Broadway, Lincoln 62656	George A. Stanford 77 Airport Rd., Lincoln 62656
MACON Members: 141-Dist. No. 7 Mary J. Bretz, Exec. Sec. 1800 E. Lake Shore Dr. Decatur 62521	A. J. Kiessel 1800 E. Lake Shore, Decatur 62521	G. Richard Locke 2300 N. Edward St., Decatur 62521
MACOUPIN Members: 19-Dist. No. 6	David Largey 205 College, Carlinville 62626	Lee Johnson 426 W. Pearl St., Staunton 62088
MADISON Members: 130-Dist. No. 6	Leo Green 1114 Milton Rd., Alton 62002	Norman E. Taylor 95 So. 9th St., E. Alton 62024
MARION Members: 37-Dist. No. 7	Percy C. May 502 N. Elm St., Centralia 62801	Walter P. Plassman Box 552, Centralia 62801
MASON Members: 6-Dist. No. 5	Dario Landasuri 125 N. Orange St., Havana 62644	Henry W. Maxfield Mason City 62664
MASSAC Members: 4-Dist. No. 9	James L. Bremer 805 Market St., Metropolis 62960	Ralph K. Frazier Hospital Dr., Metropolis 62960
MCDONOUGH Members: 26-Dist. No. 4	Donald Dexter 531 E. Grant, Macomb 61455	Stephan L. Roth Box 258, Colchester 62326
MCHENRY Members: 63-Dist. No. 1 Evelyn Rosulek, Exec. Sec. 308 E. Kimball Woodstock 60098	Vincenzo B. Petralia 210 N.W. Hgwy, Fox River Grove 60021	Clarence Hart 1110 N. Green St., McHenry 60050
MCLEAN Members: 89-Dist. No. 5	George Shonat 2304 E. Oakland, Bloomington 61701	Douglas R. Bey 900 Franklin, Normal 61761
MENARD Members: 2-Dist. No. 5	Robert J. Schafer 116 N. 5th, Petersburg 62675	Robert J. Schafer 116 N. 5th St., Petersburg 62675
MERCER Members: 5-Dist. No. 4	R. N. Svendsen 209 S. College, Aledo 61231	Monty P. McClellan 309 NW 2nd St., Aledo 61231
MONROE Members: 9-Dist. No. 10	Joseph A. Werth Waterloo 62298	Edelberto Maglasang 109 W. Legion, Columbia 62236
MONTGOMERY Members: 15-Dist. No. 5	Roger C. McFarlin 400 Rountree, Hillsboro 62049	James T. Foster 8 Arrowhead Rd., Litchfield 62056
MORGAN-SCOTT Members: 41-Dist. No. 6	Richmond H. Simmons 1515 W. Walnut, Jacksonville 62650	Robert H. Kooiker 801 Lincoln, Jacksonville 62650
MOULTRIE Members: 5-Dist. No. 7	Eugene Boros Bethany 61914	H. E. Kendall 112 E. Harrison, Sullivan 61951
OGLE Members: 19-Dist. No. 1	Thomas L. Koritz 324 Lincoln Hgwy., Rochelle 61068	Russell Zack 515 Lincoln Hgwy., Rochelle 61068
PEORIA Members: 255-Dist. No. 4 David W. Meister, Jr. Exec. Sec. 427 1st Nat. Bk. Bldg. Peoria 61602	Joseph S. Solovy 427 1st Nat. Bk. Bldg., Peoria 61602	Gene O. Hoerr 427 1st Nat. Bk. Bldg., Peoria 61602

COUNTY	PRESIDENT	SECRETARY
PERRY Members: 15-Dist. No. 10	Clarence E. Cawvey 20 N. Main, Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 6-Dist. No. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 9-Dist. No. 6	Warren C. Barrow 321 W. Washington, Pittsfield 62363	B. J. Rodriguez 868 Mortimer, Barry 62312
PULASKI Members: 1-Dist. No. 10	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 15-Dist. No. 10	V. S. Katty 312 E. Broadway, Steeleville 62288	C. S. Schlageter 101 N. Market, Sparta 62286
RICHLAND Members: 21-Dist. No. 8	Willard J. Eyer 119 Market St., Olney 62450	David R. Benson 1200 N. East St., Olney 62450
ROCK ISLAND Members: 152-Dist. No. 4 James A. Koch, Exec. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	William Kleinschmidt 621 17th Ave., East Moline 61244	J. P. Johnston 1630 5th Ave., Moline 61265
ST. CLAIR Members: 207-Dist. No. 10 Ed Belz, Exec. Dir. 4825 W. Main St. Belleville 62223	John S. Hipskind 301 W. Lincoln, Belleville 62221	Clarence J. Oerter 1915 W. Main, Belleville 62221
SALINE-POPE-HARDIN Members: 24-Dist. No. 9	Grover G. Sloan Carrier Mills 62917	Warren R. Dammers 12 Valley Forge, Harrisburg 62946
SANGAMON Members: 227-Dist. No. 5 L. R. Brosi, Exec. Sec. 2100 Lindsay Rd. Springfield 62704	James Graham 1025 S. 7th St., Springfield 62702	Robert L. Prentice 701 N. Walnut, Springfield 62702
SCHUYLER Members: 3-Dist. No. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 8-Dist. No. 7	Duncan Biddlecombe 805 W.N. 6th, Shelbyville 62565	Smith D. Taylor Box 355, Shelbyville 62565
STEPHENSON Members: 48-Dist. No. 1	William H. Isham 222 W. Exchange, Freeport 61032	Frederick M. Mosher 222 W. Exchange, Freeport 61032
TAZEWELL Members: 45-Dist. No. 5 David W. Meister, Jr. Exec. Sec. 427 1st Nat. Bk. Bldg. Peoria 61602	Albert J. Martens 427 1st Nat. Bk. Bldg., Peoria 61602	Robert M. Wright 427 1st Nat. Bk. Bldg., Peoria 61602
UNION Members: 6-Dist. No. 10	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting Box 410, Anna 62906
VERMILION Members: 81-Dist. No. 8	W. T. Shaffer 909 N. Logan, Danville 61832	L. W. Tanner 7 N. Virginia, Danville 61832
WABASH Members: 7-Dist. No. 9	Ernest Lowenstein 1128 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
WARREN Members: 10-Dist. No. 4	W. Roller 309 So. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 2-Dist. No. 10	Charles Longwell Nashville 62263	Jerry L. Beguelin Irvington Med. Ct., Irvington 62848
WAYNE Members: 6-Dist. No. 9	S. W. Konarski 407 E. Center, Fairfield 62837	C. J. Jannings III Rt. 4, Fairfield 62837
WHITE Members: 8-Dist. No. 9	S. B. Abelson South Plum St., Carmi 62821	Julius G. Harrell South Plum St., Carmi 62821

COUNTY	PRESIDENT	SECRETARY
WHITESIDE Members: 37-Dist. No. 2	Howard Christofersen R.R. 2, Sterling 61081	Timothy Sullivan 1716 Locust St., Sterling 61081
WILL-GRUNDY Members: 198-Dist. No. 11 Don M. Kline, Exec. Sec. 58 N. Chicago, Rm. 201 Joliet 60431	Leonard A. Klasta 58 N. Chicago, Joliet 60431	Antanas Razma 58 N. Chicago, Joliet 60431
WILLIAMSON Members: 28-Dist. No. 9	Robert D. Kane 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Members: 301-Dist. No. 1 Mrs. Johanna Lund Exec. Adm., 310 N. Wyman Rockford 61101	William Boswell 310 N. Wyman, Rockford 61101	Norman A. Hagman 310 N. Wyman, Rockford 61101
WOODFORD Members: 8-Dist. No. 2	K. Vaicius Minonk 61760	James W. Riley 109 S. Major St., Eureka 61530

No Organized County Society

Johnson
Marshall
Putnam

Joint County Societies

Cass-Brown	Jersey-Calhoun
Coles-Cumberland	Morgan-Scott
Henry-Stark	Saline-Pope-Hardin
Jefferson-Hamilton	Will-Grundy

A major portion of this listing will become obsolete as of January, 1974. An up-to-date listing will be published in the delegates handbook section of the March issue of the Illinois Medical Journal

Chicago Medical Society

President: Charles P. McCartney
P.O. Box 581, Palos Heights 60463
Secretary: Henrietta Herbolzheimer
5528 S. Hyde Park Blvd., Chicago 60637
Executive Administrator: Robert J. Lindley
310 S. Michigan Ave., Chicago 60604
Members: 7,110 (including Residents) District No. 3

BRANCH OFFICERS

AUX PLAINES BRANCH

President: John W. Tope
163 N. Euclid, Oak Park 60302
Secretary: Meredith B. Murray
414 S. Oak Park Ave., Oak Park 60302

CALUMET BRANCH

President: Robert J. Craven
9760 S. Kedzie Ave., Evergreen Park 60642
Secretary-Treasurer: Edwin L. Fallon
6450 S. Francisco Ave., Evergreen Park 60642

DOUGLAS PARK BRANCH

President: Loren B. Horton
7 S. Waiola Ave., La Grange 60525
Secretary: Fabian O. Ostrowski
3601 S. Austin Blvd., Cicero 60650

ENGLEWOOD BRANCH

President: Stanley Budrys
2751 W. 51st St., Chicago 60632
Secretary-Treasurer: William F. DeRose
3729 W. 96th St., Evergreen Park 60642

NORTH SUBURBAN BRANCH

President: Daniel J. Murphy
2510 Ridgeway, Evanston 60201
Secretary-Treasurer: James W. Ford
636 Church St., Evanston 60201

IRVING PARK SUBURBAN BRANCH

President: Herman Wing
400 E. Randolph St., Chicago 60601
Secretary: George Lagorio
1625 Forest Dr., Glenview 60025

JACKSON PARK BRANCH

President: Thomas W. Lester
2017 W. 107th St., Chicago 60643

Secretary-Treasurer: Ralph F. Naunton
6837 S. Euclid Ave., Chicago 60649

NORTH SHORE BRANCH

President: Arthur P. Peterson
2760 W. Foster, Chicago 60625
Secretary: Samuel Nieder
4033 N. Damen Ave., Chicago 60640

NORTH SIDE BRANCH

President: Carl F. Palumbo
1519 N. Franklin Ave., River Forest 60305
Secretary-Treasurer: Joseph C. Sherrick
303 E. Superior St., Chicago 60611

NORTHWEST BRANCH

President: Alfonso Diaz
1802 S. Racine Ave., Chicago 60608
Secretary-Treasurer: Theodore R. Tenczar
6324 N. Milwaukee Ave., Chicago 60646

SOUTH CHICAGO BRANCH

President: Anthony C. Guzauskas
10137 S. Hoyne Ave., Chicago 60643
Secretary-Treasurer: William S. Smith
1100 E. 173rd Pl., South Holland 60473

SOUTH SIDE BRANCH

President: Kermit Mehlinger
4901 Drexel Blvd., Chicago 60615
Secretary: Otto J. Keller

5825 S. Dorchester Ave., Chicago 60637

SOUTHERN COOK COUNTY BRANCH

President: Roman I. Filipowicz
28 E. Robin Lane, South Holland 60473
Secretary-Treasurer: Conrad Urban
2823 W. 173rd St., Hazel Crest 60429

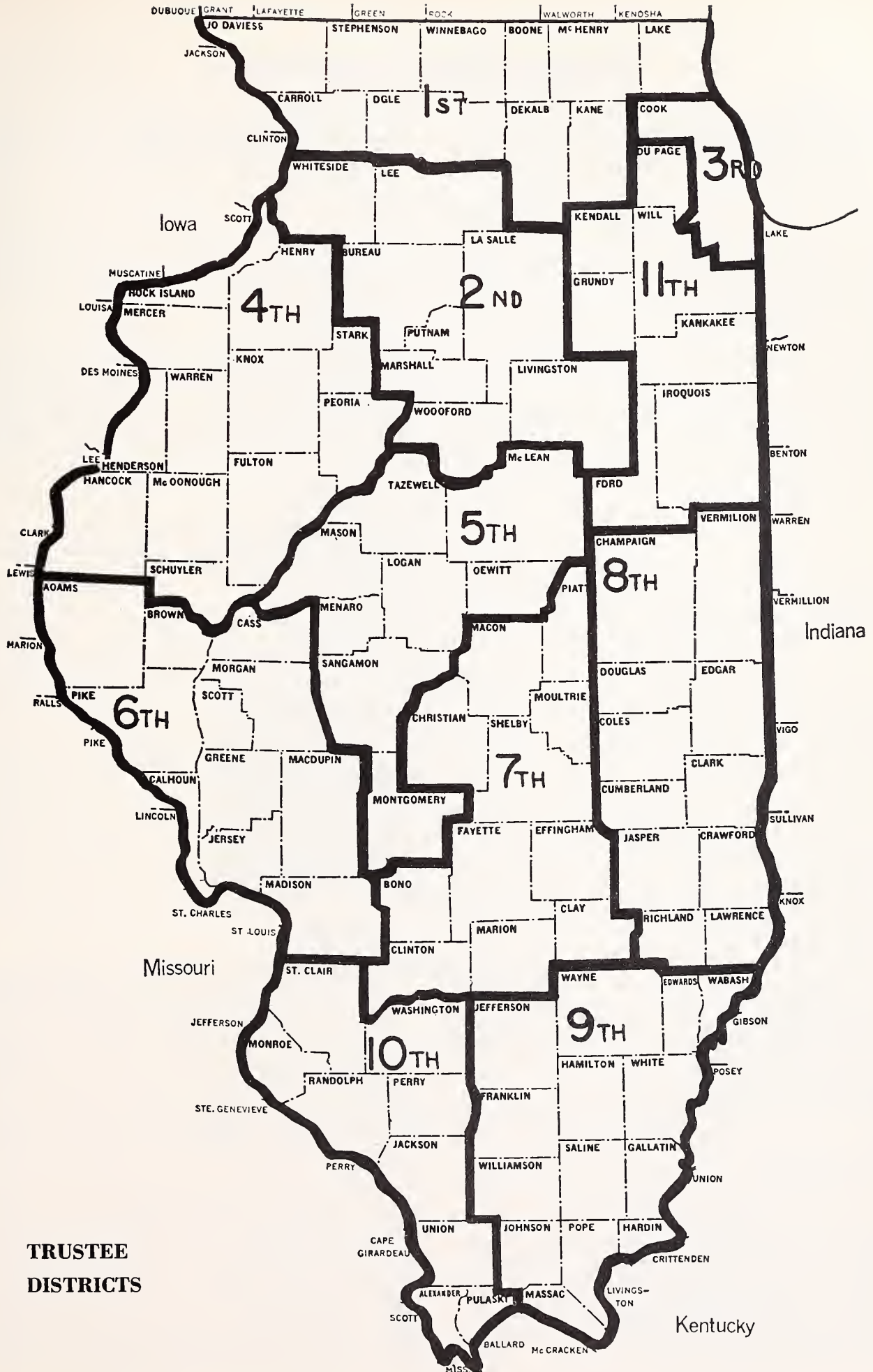
STOCK YARDS BRANCH

President: Maurice M. Hoeltgen
1836 W. 87th St., Chicago 60620
Secretary-Treasurer: Edwin J. Lukaszewski
1213 W. 51st St., Chicago 60609

WEST SIDE BRANCH

President: William J. Tansey
414 S. Oak Park Ave., Oak Park 60302
Secretary-Treasurer: Eugene T. Hoban
6429 W. North Ave., Oak Park 60302

Wisconsin



**TRUSTEE
DISTRICTS**

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Kane,
Lake, McHenry, Ogle, Stephenson, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
John H. Steinkamp, <i>Chairman</i>	1975
Gerald Liesen, St. Charles	1976
James C. Ellis, DeKalb	1974
Paul Burkholder, Rockford	1975

PEER REVIEW COMMITTEE

Russell Zack, Rochelle, <i>Chairman</i>	1976
Charles Picus, Rockford	1975
Walter J. Reedy, Waukegan	1975
John E. Madden, Freeport	1976
Rodney Nelson, Geneva	1975
Erwin A. Schilling, Rockford	1975
R. E. Whitsitt, Rockford	1975

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Lee, Livingston, Marshall,
Putnam, Whiteside, Woodford

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
K. Dexter Nelson, Princeton, <i>Chairman</i>	1974
William Erkonen, Streator	1975
Tim Sullivan, Sterling	1976

PEER REVIEW COMMITTEE

K. M. Nelson, Princeton, <i>Chairman</i>	1975
M. D. Burnstine, Sterling, <i>Co-Chairman</i>	1976
James B. Aplington, LaSalle	1976
LaMonte Ballard, Sterling	1976
Francis J. Brennan, Utica	1976
Silvio Davito, Spring Valley	1976
Bernard J. Doyle, LaSalle	1976
Donald Edwards, Dixon	1976
William Ehling, Streator	1974
Julius Kolis, Dixon	1976
P. Lymberopoulos, Dixon	1976
Edward Murphy, Dixon	1974
Rowland Musick, Mendota	1976
Theodore Mauger, Chatsworth	1975
Louis Tarsinos, Princeton	1976
Theodore W. Wagenknecht, Streator	1976

Third District

David S. Fox, Olympia Fields, *Trustee*
Robert T. Fox, Glenview, *Trustee*
Eugene T. Hoban, Oak Park, *Trustee*
Fredric D. Lake, Evanston, *Trustee*
William M. Lees, Lincolnwood, *Trustee*
George Shropshear, Chicago, *Trustee*
Philip G. Thomsen, Dolton, *Trustee*
Frederick E. Weiss, Harvey, *Trustee*
Warren Young, Crete, *Trustee*

Fourth District

Fred Z. White, Chillicothe, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox,
McDonough, Mercer, Peoria, Rock Island, Schuyler,
Stark, Warren

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Richard Icenogle, Roseville, <i>Chairman</i>	1974
John Bowman, Abingdon	1976
George Burke, Rock Island	1975

PEER REVIEW COMMITTEE

Russell Jensen, Monmouth, <i>Chairman</i>	1976
William Daugherty, Moline	1975
Donald Dexter, Macomb	1974
G. W. Giebelhausen, Peoria	1975
James C. Parsons, Geneseo	1976
Clarence Ward, Peoria	1975

Fifth District

A. Edward Livingston, Bloomington, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard,
Montgomery, Sangamon, Tazewell

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
William W. Curtis, Springfield, <i>Chairman</i>	1974
A. L. Van Ness, Bloomington	1976
Jack Means, Mason City	1975

PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, <i>Chairman</i>	1974
Robert Price, Bloomington, <i>Co-Chairman</i>	1974
Ross Billiter, Litchfield	1976
George Irwin, Bloomington	1976
John C. Meyer, Springfield	1975
Alton J. Morris, Springfield	1976
Robert B. Perry, Lincoln	1976
Robert Schaefer, Petersburg	1975
James Weimer, Pekin	1976

Sixth District

Mather Pfeiffenberger, Alton, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey,
Macoupin, Madison, Morgan, Pike, Scott

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
George F. Dietz, Granite City, <i>Chairman</i>	1976
Bernard Baalman, Hardin	1975
Edward K. DuVivier, Alton	1974
Joseph J. Grandone, Gillespie	1974
Lee Johnson, Staunton	1975

PEER REVIEW COMMITTEE

Robert R. Hartman, Jacksonville, <i>Chairman</i>	1975
Meyer Shulman, Pittsfield, <i>Co-Chairman</i>	1974
E. C. Bone, Jacksonville	1976
Bruno DeSulis, Beardstown	1974
Robert C. Murphy, Quincy	1976
Frank B. Norbury, Jacksonville	1975
James Reid, Greenfield	1974
James W. Sutherland, Quincy	1974
A. D. Wilson, Carrollton	1975

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham,
Fayette, Macon, Marion, Moultrie, Piatt, Shelby

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
Carl Sandburg, Decatur, <i>Chairman</i>	1976
Max Hirschfelder, Centralia	1974
E. H. Rames, Vandalia	1975

PEER REVIEW COMMITTEE	
Stanley Moore, Vandalia, <i>Chairman</i>	1976
E. C. Bartelsmeyer, Taylorville	1974
H. O. Hoffman, Decatur	1974
Walter P. Plassman, Centralia	1976
William Sargeant, Effingham	1976

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cum-
berland, Douglas, Edgar, Jasper, Lawrence, Richland,
Vermillion

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
Mack W. Hollowell, Charleston, <i>Chairman</i>	1974
James H. Pass, Olney	1975
Alan M. Taylor, Danville	1976

PEER REVIEW COMMITTEE	
A. R. Brandenberger, Danville, <i>Chairman</i>	1974
James W. Landis, Olney, <i>Co-Chairman</i>	1974
Eugene Johnson, Casey	1975
E. A. Kendall, Mattoon	1976
George T. Mitchell, Marshall	1975
Gordon Sprague, Paris	1976

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamilton, Har-
din, Jefferson, Johnson, Massac, Pope, Saline, Wabash,
Wayne, White, Williamson

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
Andrew Krajec, West Salem, <i>Chairman</i>	1976
Crile Doshier, Mt. Vernon	1975
Denton Farrell, Eldorado	1974

PEER REVIEW COMMITTEE	
C. J. Jannings, III, Fairfield, <i>Chairman</i>	1976
Philip Boren, Carmi	1974
James Durham, Benton	1975
Herbert Fine, Cartersville	1975
Ernest Lowenstein, Mt. Carmel	1976
Charles K. Wells, Mt. Vernon	1975

Tenth District

Herbert Dexheimer, Belleville, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry, Pulaski,
Randolph, St. Clair, Union, Washington

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
A. L. Robinson, Mounds, <i>Chairman</i>	1976
William Borgsmiller, Murphysboro	1975
Peter Soto, Belleville	1974

PEER REVIEW COMMITTEE	
Joseph A. Petrazio, Murphysboro, <i>Chairman</i>	1976
Charles Baldree, Belleville	1976
Eli Borken, Carbondale	1976
R. W. Jost, Waterloo	1975
B. Kinsman, DuQuoin	1976
Robert Rader, Anna	1974
R. E. Schettler, Red Bud	1974
William H. Walton, Belleville	1975
Charles L. Yarbrough, Cairo	1976

Eleventh District

Joseph R. O'Donnell, Glen Ellyn, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,
Kendall, Will

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
James Ryan, Kankakee, <i>Chairman</i>	1975
John Bowden, Joliet	1976
Lawrence D. Lee, Manhattan	1976

PEER REVIEW COMMITTEE	
James Campbell, Wheaton, <i>Chairman</i>	1975
James E. Dailey, Watseka	1975
James Lambert, Joliet	1976
Guy Pandola, Joliet	1975
William C. Perkins, West Chicago	1976
Julius Schweitzer, Hinsdale	1974
Victor Smith, Newark	1974

HOUSE OF DELEGATES

BOARD OF TRUSTEES

Committees of the Board

Executive Committee
Finance and Medical Benevolence Committee
Policy Committee
Publications Committee
Advisory Committee to Woman's Auxiliary
Ethical Relations Committee
Committee on Committees
Committee on Constitution and Bylaws
Governmental Health Program Reimbursement Committee

Direct Reporting Committees

Planning and Priorities Committee
Committee on Drugs and Therapeutics
Committee on Insurance
Committee to Study Certificate of Need Legislation
Committee on Redistricting and Tenure
Physician Competence Committee

Council on
Affiliate Societies

Council on
Economics and
Peer Review

Peer Review
Appeals Committee
Relative Value
Study Committee

Council on Education
and Manpower

Committee on
Accreditation
Manpower Committee
Advisory Committee to
Students and
Physicians-in-Training

Council on Environ-
mental and Community
Health

Committee on
Ear, Nose and Throat
Health
Committee on
Maternal Welfare
Committee on
Sports Medicine

Governmental Affairs
Council

Eye Health Committee
Committee on
Forensic Medicine
Committee on
Legal Definition of Death
Public Affairs
Committee

Medical Legal
Council

Committee on
Arbitration
Committee on
Laboratory Services
Ad-Hoc Committee
on Impartial Medical
Testimony

Council on
Mental Health
and Addiction

Committee on Alcoholism
and Drug Dependence

Council on Public
Relations and
Membership Services

Committee
on Membership

Council on Social
and Medical Services

Committee on Health
Care of the Poor and
Rural Problems
Committee on
Emergency and
Disaster Services
Committee on
Hospital Satellites

Officers and Directors
of the Scientific
Foundation

Administrative
Members and Directors
for the Illinois Foun-
dation for Medical Care

Directors of the
Illinois Council on
Continuing Medical
Education

Members of the
Annual Meeting
Joint Management
Committee

Representatives to
the Student Loan
Fund Board

Illinois Professional
Standard Review
Organization

LIAISON TO RELATED
MEDICAL GROUPS AND
REPRESENTATIVES
TO PARAMEDICAL
ORGANIZATIONS

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

COUNCIL ON ECONOMICS AND PEER REVIEW

Fred A. Tworoger, *Chairman*
4753 Broadway, Chicago 60640
Robert J. Becker, *Vice-Chairman*
229 N. Hammes, Joliet 60435
Charles E. Baldree, Jr.
26 E. Washington, Belleville 62220
Alfred Clementi
675 W. Central Rd., Arlington Heights 60004
Edward DuVivier
1900 Brown St., Alton 62002
John L. Eaton
2855-18th St. C, Moline 61265
Earl E. Fredrick, Jr.
10830 Halsted St., Chicago 60628
R. Gregory Green
1355 Charles St., Rockford 61108
A. Beaumont Johnson
860 Summit St., Elgin 60120
Henry P. Russe
1030 Ashland Ave., River Forest 60305
Maynard I. Shapiro
7531 Stony Island Ave., Chicago 60649
Joseph Silverstein
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Eugene P. Johnson
P.O. Box 68, Casey 62420
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
Frederick E. Weiss
15643 Lincoln, Harvey 60426

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INTERN-RESIDENT MEMBERS:

Raymond H. Nootens
211 Park Ave., River Forest 60305
Ronald T. Staubly, *Alternate*
215 S. 3rd St., Elkhart 62634

STAFF: Joseph J. Lotharius

Committees:

Peer Review Appeals
Relative Value Study

Responsibilities and Purposes

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (HMOs, prepaid programs); 5) health care planning programs (CHP, IRMP, etc.), 6) serving as the appellate body for peer review in the state.

PEER REVIEW APPEALS COMMITTEE

Council Members:

Robert J. Becker, *Chairman*
Edward DuVivier
John L. Eaton
Earl E. Fredrick, Jr.
Henry P. Russe
STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and quantity of medical care. The committee also serves as liaison to local peer review committees and offers its assistance whenever requested.

RELATIVE VALUE STUDY COMMITTEE

Council Member:

Robert J. Becker, *Chairman*

Non-Council Members:

Joseph L. D'Silva
513 Kin Court, Wilmette 60091
Theodore Grevas
1800-3rd Ave., Rock Island 61201
Clifton L. Reeder
734 N. Merrill Ave., Park Ridge 60068

Ben Williams

1400 W. Park Ave., Urbana 61801

CONSULTANT:

Jacob E. Reisch
1129 S. 2nd St., Springfield 62704

STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The Committee's purpose is a positive effort to study the feasibility of developing or updating an Illinois relative value study.

COUNCIL ON EDUCATION AND MANPOWER

Morgan M. Meyer, *Chairman*
815 S. Main, Lombard 60148
Allison Burdick, Jr., *Vice Chairman*
(*Adv. to Physicians-in-training*)
1637 N. Mobile Ave., Chicago 60639
Herschel L. Browns, (*Accreditation*)
4600 N. Ravenswood, Chicago 60640
Jack L. Gibbs
175 S. Main St., Canton 61520
Lawrence L. Hirsch
836 Wellington, Chicago 60657
J. Ernest Breed
(*Liaison to Illinois Council on CME*)
55 E. Washington St., Chicago 60602
George O. Dohrmann
3000 Logan Blvd., Chicago 60647
John Holland
700 N. 7th, c/o Physicians Grp., Springfield 62702
Donald Stehr (*Student Loan Fund*)
102 E. Market, Havana 62644

CONSULTANTS:

Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
Fred Z. White
723 N. 2nd St., Chillicothe 61523
Allan L. Goslin
712 N. Bloomington, Streator 61364

SAMA REPRESENTATIVES:

Jeff Waitzman, U. of I.
1431 W. Farwell, Chicago 60626
Michael Hughey, Loyola
711 Loral Ave., Wilmette 60091

INTERNS AND RESIDENTS:

Bruce Fagel
10077 Linda Lane, Des Plaines 60016

REPRESENTATIVES OF MEDICAL SCHOOLS:

Chicago Medical School
James Shaffer
2020 Ogden Ave., Chicago 60612

Loyola University Stritch School of Medicine
William B. Rich
2160 S. 1st Ave., Maywood 60153
University of Southern Illinois Medical School
Dax Taylor
715 E. Carpenter, Springfield 62702
Rush Medical School
John Graettinger
Rush Presbyterian-St. Lukes Medical Center,
Chicago 60612
Univ. of Illinois College of Medicine
Robert L. Evans, Dean
1601 Parkview, Rockford 61101
Northwestern Medical School
Jacob R. Suker
303 E. Chicago, Chicago 60611
University of Chicago—Pritzker School of Medicine
Clifford W. Gurney
950 E. 59th St., Chicago 60637

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with the advisory committee to students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:

Accreditation
Liaison to Council of Deans
Manpower
Advisory Committee to Students and
Physicians-in-Training

ACCREDITATION SUBCOMMITTEE

Council Members:

Herschel Browns, *Chairman*
George Dohrmann
Jack L. Gibbs

Non-Council Members:

John Huss
172 Schiller St., Elmhurst 60126
Ross Hutchison
126 E. 9th St., Gibson City 60696
Rex O. McMorris
619 N.E. Glen Oak Ave., Peoria 61603

L. P. Johnson
1601 Parkview Ave., Rockford 61101

Responsibilities and Purposes:

To review survey reports of institutions which have applied for accredited status and grant accreditation to promote Continuing Medical Education activities; to provide liaison with the Illinois Council on Continuing Medical Education.

STAFF: Richard A. Ott

LIAISON COMMITTEE to the COUNCIL OF DEANS

Council Members:

Jack L. Gibbs
John M. Holland

Governmental Affairs Council Representative:

Edward G. Ference
932 S. 2nd Street, Springfield 62704

MANPOWER SUBCOMMITTEE

Council Member:
Donald Stehr, *Chairman*

Non-council Members:
William Durham
203 N. Vine St., Harrisburg 62946
Charles R. Frazer
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Roger Hendricks
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Kermit Mehlinger
4901 S. Drexel Blvd., Chicago 60615

SAMA REPRESENTATIVE:
Michael Hughey
711 Loral Ave., Wilmette 60091

STAFF: James R. Slawny

Responsibilities and Purposes:

To evaluate physician manpower and distribution problems and devise means of supplying physicians to areas of need.

ADVISORY COMMITTEE TO MEDICAL STUDENTS AND PHYSICIANS-IN-TRAINING

Allison Burdick, Jr., *Chairman*
10 W. Ontario, Oak Park, 60302
Gerald Berkowitz, *Vice Chairman*
1031 Cobbleston Ct., Northbrook 60002
Arthur Appleyard, D.O.
821 Birdwood Lane, LaGrange 60525
Carl Barthelemy
175 S. Main St., Canton 61520
Eli Borkon
Box 1030, Carbondale 62901
Richard Locke
2300 N. Edward St., Decatur 62521
John J. Taraska
Methodist Hospital, Peoria 61603

Student Representatives:
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711 Laurel Ave., Wilmette 60091
Frank Matheu (CCOM)
4909 S. Kedvale, Chicago 60632
Boyd McCracken, Jr. (Chicago Medical School)
433 S. Lombard, Oak Park 60302
Alan M. Roman (MECO)
2121 Collette Ln., Flossmoor 60422
Tom Stibolt (Rush)
1360 N. Sandburg Terr., Chicago 60610
Jeff Waitzman (Illinois)
1431 W. Farwell, Chicago 60626
William Yasnoff (Northwestern)
710 N. Lake Shore Dr., Chicago 60611
STAFF: Perry L. Smithers

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Edward A. Piszczek, *Chairman*
6410 N. Leona, Chicago 60646
John Ballenger
(*Liaison with EENT and otolaryngology societies*)
723 Elm St., Glencoe 60093
Thomas Davison
(*Liaison with industrial medicine*)
Chicago and North Western Railway Co.
17 North Clinton St., Chicago 60658
Eugene F. Diamond
(*Nutrition Conference Coordinator*)
11055 S. St. Louis Ave., Chicago 60658
Robert Hartman
(*Comm. on Maternal Welfare*)
1515A W. Walnut, Jacksonville 62650
John Hipskind
301 W. Lincoln, Belleville 62221
Julius Kowalski
(*Liaison with environmental groups*)
436 Park Ave., E., Princeton 61356
Daniel Pachman
(*Liaison with Pediatric Coordinating Council*)
1212 N. Lake Shore Drive, Chicago
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Ill. Dept. of Public Health
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State of Illinois, Dept. of Public Health
535 W. Jefferson St., Springfield 62706

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SAMA REPRESENTATIVE:
Richard Hector, Loyola
918 N. 5th Ave., Maywood 60153

INTERNS AND RESIDENTS:
Marc Rose
7401 N. Kostner Ave., Skokie

STAFF: Jack W. Magness

Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and

problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

Committees:

Ear, Nose and Throat Health
Maternal Welfare
Sports Medicine

COMMITTEE ON EAR, NOSE AND THROAT HEALTH

John Ballenger, *Chairman*
723 Elm Street, Winnetka 60098
Andreas Kodros
47 Park Lane, Golf 60029
William Weiss
118 W. Lural St., Springfield
R. Marcus
1301 N. Forest Glen Dr., Winnetka 60093
Guy Pfeiffer
213 S. 17th St., Mattoon 61938

STAFF: Jack W. Magness

Responsibilities and Purposes:

The function of the Ear, Nose and Throat Health Committee is to concern itself with state legislation regarding Laryngological and Otological matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Ear, Nose and Throat Health Committee shall also work in connection with the Chicago Laryngological and Otological Society.

COMMITTEE ON MATERNAL WELFARE

Robert R. Hartman, *Chairman*
1515A W. Walnut St., Jacksonville 62650
Frederick H. Falls, *Chairman Emeritus and Special Consultant*
Box 47, River Forest 60305

DISTRICTS MEMBERS AND ALTERNATES (alternates in italics)

1. William R. Larsen
13707 E. Jackson, Woodstock 60098
Gordon T. Burns
2300 N. Rockton, Rockford 61101
2. William J. Farley
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Donald M. Gallagher
Box 538, Granville 61326
3. Melvin Goodman
13826 Lincoln Ave., Dolton 60419
Charles F. Kramer
12647 S. Justine St., Calumet Park 60643
4. V. B. Adams
301 E. Jefferson, Macomb 61455
Ralph Gibson
416 St. Marks Ct., Peoria 61603
5. William W. Curtis
100 W. Miller, Springfield 62702
Robert Maletich
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6. Robert R. Hartman
1515A Walnut St., Jacksonville 62650
Richard Yoder
601 E. 3rd, Alton 62002
7. Paul A. Raber
149 W. King, Decatur 62521
Hubert Magill
1170 E. Riverside, Decatur 62521

8. John C. Mason Jr.
715 N. Logan, Danville 61832
J. Roger Powell
602 W. University, Urbana 61801
9. William B. Skaggs
Doctor's Clinic, 203 N. Vine, Harrisburg 62946
Donald R. Risley
319 Market St., Mt. Carmel 62863
10. Arthur A. Smith
306 E. Eighth St., O'Fallon, 62269
William J. Malony
Western Heights, Carbondale 62901
11. John J. McLaughlin
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Charles P. Westfall
172 Schiller, Elmhurst 60126

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Willard C. Scrivner
Suite #2, 6600 W. Main St.
Belleville 62223
Augusta Webster
707 N. Fairbanks Ct., Chicago 60611

STAFF: Richard A. Ott

Responsibilities and Purposes:

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.

AD-HOC COMMITTEE ON SPORTS MEDICINE

Council Members:

Julius Kowalski, *Chairman*
Eugene F. Diamond

Non-Council Members:

James P. Campbell
322 N. Blanchard, Wheaton 60187

STAFF: Jack W. Magness

Responsibilities and Purposes:

The Committee's purpose is to promote safe, healthful athletic activities for all Illinois children. The Committee will encourage conferences and other programs to educate trainers and coaches on the proper handling of injuries and the physical and psychological problems of athletic participation by children. It will cooperate with programs which encourage high school students to consider training as a career.

GOVERNMENTAL AFFAIRS COUNCIL

George T. Wilkins, *Chairman*
3165 Myrtle Ave., Granite City 62040
James Laidlaw, *Vice Chairman*
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Noel Bass
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George Burke
Rock Island Franciscan, 2701 Seventeenth St.,
Rock Island 61201
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Alfred J. Faber
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Edward G. Ference
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John W. Ovitz
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Warren Tuttle
203 N. Vine, Harrisburg 62946

Pam Taylor (Mrs. Alan)
1607 N. Vermilion, Danville 61832

INTERN:

James J. McCoy, Dept. of Family Practice
McNeal Memorial Hospital, Berwyn 60402

SAMA REPRESENTATIVES:

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5040 W. Gunnison, Chicago 60630
Tom Powers
110 S. Lincoln, Addison 60101

AUXILIARY REPRESENTATIVE:

Lois (Mrs. Paul) Raber
1548 W. Macon St., Decatur 62522

STAFF:

J. Bernie Robinson
Larry N. Booth
Betty Kararo

Responsibilities and Purposes

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Eye Health
Forensic Medicine
Legal Definition of Death
Public Affairs

EYE HEALTH COMMITTEE

Council Member:

Warren W. Kreft, *Chairman*

Non-Council Members:

Frederick Crowley
117 Bellemont Road, Bloomington 61701
Maurice M. Hoeltgen
1836 West 87th St., Chicago 60620
Paul Hauser
2500 Ridge Ave., Evanston 60201

Edward Kwedar
615 S. 7th, Springfield 62703
Samuel Schall
30 N. Michigan, Chicago 60602
Frank Snell
334 West Main, Decatur 62522
Robert W. Webb
213 South Charles, Edwardsville 62025

STAFF: Larry N. Booth

COMMITTEE ON FORENSIC MEDICINE

Council Member:

Grant C. Johnson, *Chairman*

Non-Council Members:

Thomas P. DeGraffenried
1208 Sunnymead, DeKalb 60115

James H. Ryan

401 North Wall, Kankakee 60901

Robert W. Wissler

950 East 59th St., Chicago 60637

STAFF: Larry N. Booth

COMMITTEE ON LEGAL DEFINITION OF DEATH

Jacob E. Reisch, *Chairman*

1129 S. 2nd St., Springfield 62704

Tom Baffes

Dept. of Surgery, Mt. Sinai Hospital

California Ave. at 15th St., Chicago 60608

Benjamin Boshes

251 East Chicago Ave., Chicago 60611

Fred Merkel

151 Sheridan Road, Kenilworth 60643

William Dye

3200 Highland, Downers Grove 60515

STAFF: Larry N. Booth

PUBLIC AFFAIRS COMMITTEE

Council Members:

Elliott Partridge, *Chairman*

Robert Pierce, *Vice Chairman*

George T. Wilkins

James Laidlaw

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Eugene H. Siegel

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A. E. Steer

701 N. Walnut St., Springfield 62702

Lorin D. Whittaker

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AUXILIARY REPRESENTATIVE:

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9 Litchfield Lane, Champaign 61820

STAFF: Bob Kjellander

MEDICAL-LEGAL COUNCIL

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30 N. Michigan, Chicago 60602

James Habegger, *Vice Chairman*

(Laboratory Services)

32 S. Lincoln, Geneva 60134

Vincent Sarley (IMT)

682 Pine, Deerfield 60015

Clinton L. Compere

(Arbitration)

737 N. Michigan, Chicago 60611

Donal O'Sullivan

203 Forest Ave., Oak Park 60302

Harold Sofield

715 Lake St., Oak Park 60301

Herman Wing

400 E. Randolph, Chicago 60601

Leonard Klawns

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Clyde Phillips

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P. John Seward

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Allan Goslin

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Frederick E. Weiss

15643 Lincoln, Harvey 60426

A. Everett Joslyn

(Liaison with Insurance Comm.)

557 Keystone Ave., River Forest 60305

James Fletcher, Esq.

c/o Burditt and Calkins, 135 S. LaSalle St.,
Chicago 60603

INTERNS AND RESIDENTS:

Cheng H. Hsu

244 Ann St., Clarendon Hills 60514

SAMA REPRESENTATIVES:

Gary Skaletsky, U. of I.

3865 W. Fargo, Skokie 60076

John Dowdle, Loyola University

5465 S. Everett, Chicago 60615

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both

federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in personal injury situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois and encourage the use of medical diagnostic laboratories supervised by duly qualified physicians. In addition, the council shall be concerned with licensing and standards of practice and quackery.

Committees:

Arbitration

Impartial Medical Testimony

Interprofessional Code

Laboratory Services

COMMITTEE ON ARBITRATION

Council Members:

Clinton L. Compere, *Chairman*

William Schwingel

David T. Petty

Vincent Sarley

STAFF: Richard A. Ott

Responsibilities and Purposes:

The committee shall review alternatives available to the medical profession in amelioration of professional liability litigation; to this end it is engaged in establishing pilot projects for screening panels, hospital arbitration or other activities.

COMMITTEE ON LABORATORY SERVICES

James Habegger, *Chairman*

32 S. Lincoln Ave., Geneva 60134

Coye Mason, *Vice Chairman*

4720 W. Montrose, Chicago 60641

Richard Novak

1601 Parkview, Rockford 61107

Peter Soto

St. Elizabeth's Hospital, Belleville 62221

Earl Suckow

617 Glendale Lane, Mt. Prospect 60056

Thiru Vaithianathan

4224 W. Grove, Skokie 60076

Karl Sohlberg

Methodist Hospital, Peoria 61603

STAFF: Jack W. Magness

Responsibilities and Purposes:

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Marshall A. Falk, *Chairman*

4700 N. Clarendon, Chicago 60640

Ronald Schlensky, *Vice Chairman*

251 E. Chicago, Suite 930, Chicago 60611

Nathaniel S. Apter

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Alex Spadoni

(ISMS/IPS Peer Review)

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LeRoy Levitt, Director

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460 W. Deming Pl., Apt. 3E, Chicago 60614

AUXILIARY REPRESENTATIVE:

Mrs. Ralph Davis

2639 Vermont, Quincy 62301

STAFF: Richard A. Ott

Committees:

Alcoholism and Drug Dependence
ISMS/IPS Peer Review Consulting
Physician Competence

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees

on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

W. David Steed, *Chairman*

1011 Lake St., Suite 423, Oak Park 60301

Albert Ray

301 N. Reed St., Joliet 60435

Charles Anderson

120 N. Oak St., Hinsdale 60521

George Silvest

Lowell Park Road, Dixon 61021

David Stinson

4402 N. Main St., Rockford 61103

Kermit Mehlinger

4901 Drexel Blvd., Chicago 60615

CONSULTANT:

Joseph H. Skom

707 N. Fairbanks Ct., Chicago 60611

STAFF: Jack W. Magness

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions will include: (1) study, research and dissemination of educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Lee F. Winkler, *Chairman*

850 S. 4th St., Springfield 62703

Paul J. Biedenharn, *Vice-Chairman*

Medical Arts Bldg., New Baden 62265

Sheldon Berger

707 N. Fairbanks Ct., Chicago 60611

Raymond H. Conley

112 S. Northwest Hwy., Park Ridge 60068

Karl T. Deterding

St. James Profess. Bldg., Suite 109

612 E. Water St., Pontiac 61764

Catherine L. Dobson

5842 Stony Island Ave., Chicago 60637

Charles W. Pfister (Liaison with Clergy)

5511 N. Harlem, Chicago 60656

Herbert Sohn

4640 N. Marine Dr., Chicago 60640

Alan Taylor

1012 W. Fairchild, Danville 61832

CONSULTANTS:

Robert T. Fox

2136 Robin Crest Ln., Glenview 60025

Fredric D. Lake

1041 Michigan Ave., Evanston 60202

Robert B. Lynn

209 Henry St., Alton 62002

Douglas P. Rhone

140 Riverside Rd., Riverside 60546

Philip G. Thomsen

13826 Lincoln Ave., Dolton 60419

Charles J. Weigel

7579 Lake St., River Forest 60305

AUXILIARY REPRESENTATIVE:

Mrs. Donovan Stiegel

2920 15th Ave., Moline 61265

STAFF: Shideler Harpe

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

COUNCIL ON SOCIAL & MEDICAL SERVICES

James C. Reid, *Chairman*

721 S. College, Greenfield 62044

John W. Bowden

330 N. Madison, Joliet 60435

Matthew B. Eisele

3 Kilmar Woods, Belleville 62223

Kenneth A. Hurst

157 S. Lincoln, Aurora 60505

Robert P. Johnson

108 Maple Grove, Springfield 62707

Max Klinghoffer

127 E. Vallette, Elmhurst 60126

Bertram A. Moss (*Liaison w/Aging*)

1401 N. California, Chicago 60622

Joel Rosen (*Liaison w/DVR psychiatrists*)

401 E. Ohio St., Chicago 60611

Aaron M. Rosenthal
4700 N. Clarendon, Chicago 60640
James W. Sutherland
1305 Broadway, Quincy 62301
Sheldon S. Waldstein
950 Skokie Blvd., Northbrook 60062

CONSULTANT:

Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936

SAMA REPRESENTATIVE:

Paul Stromborg
1428 S. Maple, Berwyn 60402

INTERN-RESIDENT MEMBERS:

Alfonso De La Morena
2 So. 711 LaTour Ave., Oakbrook 60521
Carl C. Bell, (Alternate)
5111 S. University, Chicago 60615

STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The Council on Social and Medical Services shall initiate and implement programs related to health care facilities, hospital services, emergency room and disaster medical care; maintain liaison with the nursing profession and other health-oriented organizations, including the Illinois Department of Vocational Rehabilitation; handle problems related to aging, rural health and health care of the poor.

Committees:

Committee on Health Care of the
Poor & Rural Problems
Committee on Emergency & Disaster Services
Committee on Hospital Satellites

COMMITTEE ON HEALTH CARE OF THE POOR AND RURAL PROBLEMS

Council Member:

Aaron M. Rosenthal, *Chairman*

Non-Council Members:

Paul W. Clark
7 W. Center St., Mt. Morris 61054
Audley F. Connor, Jr.
3233 S. King Dr., Chicago 60616
Lawrence Hirsch
836 Wellington, Chicago 60657
Alfred D. Klinger
5229 S. Woodlawn Ave., Chicago 60616
Harold A. Paul
1725 W. Harrison, Chicago 60612
Alphonso Robinson
104 N. Front St., Mounds 62964
Donald E. Stehr
102 E. Market St., Havana 62644

CONSULTANTS:

Willard C. Scrivner
6600 W. Main, Suite 2, Belleville 62223

Fred Z. White
723 N. 2nd St., Chillicothe 61523
Robert B. Greifinger
R.I. Neighborhood Health Center
520-12th, Rock Island 60201
Gary B. Schwartz
AMA, 535 N. Dearborn, Chicago 60610
Wali M. Siddiq
Council on Science & Health Manpower Development
4649 S. King Dr., Chicago 60653
Mrs. Carmen T. Lewis
ASPIRA, 767 N. Milwaukee Ave., Chicago 60622

STAFF: Larry S. Boress

Responsibilities and Purposes:

The committee's responsibility is to mobilize and utilize the resources of the medical profession to achieve available and acceptable health care for the poor and for those living in rural areas.

COMMITTEE ON EMERGENCY AND DISASTER CARE

Council Members:

Matthew B. Eisele, *Chairman*
Max Klinghoffer, *Vice-Chairman*

Non-Council Members:

Earl W. Donelan
2425 S. Glenwood Ave., Springfield 62704
Ralston R. Hannas, Jr.
1558 W. Fork Dr., Lake Forest 60045
William A. Hark
1725 W. Harrison, Chicago 60612
Stanley E. Ruzich
9944 S. Damen, Chicago 60643

CONSULTANTS:

Eugene P. Johnson
P.O. Box 68, Casey 62420
Allan L. Goslin
712 N. Bloomington, Streator 61364

STAFF: Larry S. Boress

Responsibilities and Purposes:

This committee is concerned with improving the delivery of health care in emergency situations. The committee will monitor the effectiveness of emergency medical service programs as they exist throughout the state. It will also assist local and state agencies to evaluate new programs in emergency and disaster health care.

COMMITTEE ON HOSPITAL SATELLITES

Council Members:

Sheldon S. Waldstein, *Chairman*
John W. Bowden
James W. Sutherland

CONSULTANT:

Samuel R. Cloninger
64 Old Orchard, Skokie 60076

STAFF: Larry S. Boress

Responsibilities and Purposes:

There is a growing trend for hospitals to build satellite facilities outside of their geographic service areas. The Committee on Hospital Satellites will study how such facilities affect physicians and the health care needs of the area which the satellite serves.

COUNCIL ON AFFILIATE SOCIETIES

Robert Bettasso
Ill. Chap., American College of Surgeons
628 Columbus, Ottawa 61350

Lawrence Breslow
Ill. Chap., American Academy of Pediatrics
1500 Shermer Rd., Northbrook 60062

Edward Brunner
Ill. Society of Anesthesiology
301 East Chicago, Chicago 60611

W. B. Buckingham
Ill. Society of Internal Medicine
319 Linden, Oak Park 60302

Samuel Cloninger
Ill. Radiological Society
64 Old Orchard, Skokie 60076

Norman M. Frank
Ill. Chap., American Academy of Family Physicians
421 Park Ave., Clarendon Hills 60514

Jack Gibbs
Ill. Surgical Society
175 Main St. So., Canton 61520

David Helberg
Ill. Assoc. of Ophthalmology
1702 Washington St., Waukegan 60085

James M. Holland
Chicago Urological Society
2650 Ridge Ave., Evanston 60201

W. R. Malony
Ill. Ob-Gyn Society
Carbondale Clinic, Box 1030, Carbondale 62901

George Pollock
Ill. Psychiatric Society
180 N. Michigan, Chicago 60601

Simon Ramah
Ill. Society of Pathology
6301 So. County Line Rd., Hinsdale 60521

E. B. Sylvester
Ill. Chap., American College of Ob-Gyn
57 N. Ottawa, Joliet 60431

STAFF: James R. Slawny

Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

Committees of the Board of Trustees

COMMITTEE ON CONSTITUTION & BYLAWS

Joseph R. O'Donnell, *Chairman*
444 Park Blvd., Glen Ellyn 60137

Herbert Dexheimer
301 S. Illinois, Belleville 62220

Allan L. Goslin
712 N. Bloomington, Streator 61364

A. Edward Livingston,
219 N. Main St., Bloomington 61701

Warren Tuttle
293 N. Vine St., Harrisburg 62946

CONSULTANTS:

James Fletcher
Burdett & Calkins, 135 S. LaSalle St., Chicago 60603

Andrew J. Brislen
6060 Drexel Ave., Chicago 60637

David S. Fox
826 E. 61st St., Chicago 60637

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

COMMITTEE ON COMMITTEES

Allan L. Goslin, *Chairman*
712 Bloomington, Streator 61364

George Shropshire
1525 E. 53rd St., Chicago 60615

Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Committees shall consist of three

members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

ETHICAL RELATIONS COMMITTEE

Paul Sunderland, *Chairman*
214 N. Sangamon, Gibson City 60936
Joseph Skom
707 Fairbanks Ct., Chicago 60611
Joseph O'Donnell
444 Park, Glen Ellyn 60137
Arthur Goodyear
142 East Prairie, Decatur 62523
STAFF: Roger N. White

Responsibilities and Purposes

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures*.

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board of review. (Appeals must be ac-

companied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EXECUTIVE COMMITTEE

William M. Lees, *Chairman*
6518 North Nokomis, Lincolnwood 60646
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest, 60305
Willard C. Scrivner
Suite #2, 6600 West Main, Belleville 62223
Mather Pfeifferberger
State and Wall Sts., Alton 62002
Joseph L. Bordenave
1665 South St., Geneva 60134
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
Fredric D. Lake
1041 Michigan Ave., Evanston 60202
Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936

STAFF: Roger N. White

Responsibilities and Purposes

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Mather Pfeifferberger, *Chairman*
State & Wall Streets, Alton 62002
Jacob E. Reisch
1129 South 2nd Street, Springfield 62704
Robert Fox
2136 Robin Crest, Glenview 60025
Fred Z. White
723 North Second Street, Chillicothe 61523
STAFF:

Roger N. White
Richard D. Hengl

Responsibilities and Purposes

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for

the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.

2. Keep the names of the beneficiaries confidential and known only to the committee.

3. Determine the allotment for each recipient.

4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Philip G. Thomsen, *Chairman*
13826 Lincoln, Dolton 60419
Herbert Dexheimer
301 S. Illinois, Belleville 62220
Eugene P. Johnson
P.O. Box 68, Casey 62420
George Shropshire
1525 E. 53rd, Chicago 60615
Warren D. Tuttle
203 N. Vine, Harrisburg 62946

Frederick E. Weiss
15643 Lincoln, Harvey 60426

CONSULTANT: Jacob E. Reisch

STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid and CHAMPUS.

POLICY COMMITTEE

Joseph L. Bordenave, *Chairman*
1665 South St., Geneva 60134
Andrew J. Brislen
6060 Drexel Ave., Chicago 60637
David S. Fox
20829 Greenwood Center Ct., Olympia Fields 60461

Responsibilities and Purposes

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

STAFF: Perry Smithers

PUBLICATIONS COMMITTEE

Jacob E. Reisch, *Chairman*
1129 South Second St., Springfield 62704
Warren W. Young
3450 Haweswood Dr., Crete 60417
Eugene T. Hoban
6429 North Ave., Oak Park 60302
Frederick E. Weiss
15643 Lincoln, Harvey 60426
James A. McDonald
13 S. 2nd Street, Geneva 60134

and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

STAFF: Richard A. Ott

Responsibilities and Purposes

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Fredric D. Lake, *Chairman*
1041 Michigan, Evanston 60202
Willard C. Scrivner
Suite #2, 6600 W. Main, Belleville 62223
William M. Lees
6518 N. Nokomis, Lincolnwood 60646

Responsibilities and Purposes

The committee shall consist of the president-elect as chairman, the president, the chairman of the Board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

STAFF: Roger N. White

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees will be formed from time to time, at the time of publication the following groups had been established.

ANNUAL MEETING JOINT MANAGEMENT COMMITTEE

Paul W. Sunderland, *Chairman*
214 N. Sangamon St., Gibson City 60936
Joseph Bordenave
1665 South St., Geneva 60134
Jacob E. Reisch
1129 S. Second St., Springfield 62704
Harold A. Sofield
715 Lake St., Oak Park 60301
Andrew Thomson
1725 W. Harrison St., Chicago 60612
Fred A. Tworoger
4753 Broadway, Chicago 60640
Fred Z. White
723 N. Second St., Chillicothe 61523
Francis W. Young
10025 S. Hamilton, Chicago 60643

STAFF: Perry Smithers

Responsibilities and Purposes:

The committee, consisting of equal numbers of representatives of the Chicago Medical Society and ISMS members outside of Cook County is responsible for the overall management of the Midwest Clinical Conference, which is co-sponsored annually by the two organizations, in cooperation with various medical specialty groups. This committee establishes broad policy for the convention, including the setting of dates and place for the meeting, decides on the general format of the program, delineates the areas of responsibility for the major co-sponsoring organizations, and oversees the budget for the conference.

COMMITTEE ON DRUGS AND THERAPEUTICS

Robert C. Muehrcke, *Chairman*
518 North Austin Blvd., Oak Park 60302
Richard L. Landau, *Vice Chairman*
950 E. 59th St., Chicago 60637
Joseph D. Cece, Jr.
120 Oakbrook, Oak Brook 60521
Charles R. Frazer, Jr.
1401 Gaty Ave., East St. Louis 62201
William H. Walton
109 S. High St., Belleville 62220
Andrew Krajec
108 W. South St., West Salem 62476
Arthur Marks
101 E. Center St., Fairfield 62837

CONSULTANTS:

Louis Gdalmann, R.Ph.
5418 S. East View Park 60615
Richard H. Suhs
1409 Stevenson Drive, Springfield 62703

STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

COMMITTEE TO STUDY CERTIFICATE OF NEED LEGISLATION

Frank J. Jirka, Jr. *Chairman*
1507 Keystone, River Forest 60305
Alfred Faber
2100 Swainwood Dr., Glenview 60025
Joseph O'Donnell
444 Park Blvd., Glen Ellyn 60137

William M. Lees
6518 N. Nokomis, Lincolnwood 60646
J. Ernest Breed
55 E. Washington, Chicago 60602
George T. Wilkins
1204 27th St., Granite City 62040
STAFF: Roger N. White

COMMITTEE ON INSURANCE

Lawrence Knox, M.D., *Chairman*
1200 N. East St., Olney 62450
Philip D. Boren, *Vice Chairman*
S. Plum St., Carmi 62821
Martin Compton
3003 E. Oakland Ave., Bloomington 61701
A. Everett Joslyn
557 Keystone Ave., River Forest 60305
Theodore LeBoy
917 Norwood Dr., Melrose Park 60160
Charles W. Schlagater
2950 Payne Ave., Evanston 60201

CONSULTANTS:

David S. Fox
826 E. 61st St., Chicago 60637
A. Edward Livingston
219 N. Main St., Bloomington 61701

Jacob E. Reisch
1129 S. Second St., Springfield 62704
Fred Z. White
723 N. Second St., Chillicothe 62864

STAFF: Perry L. Smithers

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, Group Life Insurance and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

PLANNING AND PRIORITIES COMMITTEE

Willard C. Scrivner, *Chairman*
Suite 2, 6600 W. Main, Belleville 62223
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
Philip G. Thomsen
13826 Lincoln, Dolton 60419
William M. Lees
6518 N. Nokomis, Lincolnwood 60646

Fredric D. Lake
1041 Michigan, Evanston 60202
Alfred W. Faber
2100 Swainwood Drive, Glenview 60025

STAFF:

Roger N. White
J. Bernie Robinson

COMMITTEE ON REDISTRICTING & TENURE

J. M. Ingalls, *Chairman*
502 Shaw, Paris 619444
John Ring, *Vice-Chairman*
511 E. Hawley St., Mundelein 60060
Julian Buser
6600 W. Main, Belleville 62223
E. Newton DuPuy
1101 Maine St., Quincy 62301
C. Larkin Flanagan
720 N. Michigan, Chicago 60611
Jere E. Freidheim
3050 Wallace, Chicago 60616
Aaron B. Gerber
23450 Western, Park Forest 60466
Lawrence Hirsch
836 Wellington, Chicago 60657

Wayne Leimbach
1240 N. Highland, Aurora 60506
Eugene T. Leonard
1215 N. Alpine, Rockford 61102

CONSULTANTS:

Fredric D. Lake
1041 N. Michigan Ave., Evanston 60602
Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
Warren D. Tuttle
213 N. Vine St., Harrisburg 62946

STAFF: James R. Slawny

Responsibilities and Purposes:

To conduct studies to obtain sufficient information for future redistricting of ISMS and to review the terms of office of officers and trustees.

PHYSICIAN COMPETENCE COMMITTEE

Thomas W. Stach, *Chairman*
(*Council on Mental Health and Addiction*)
620 Oak Brook Prof. Bldg., Oak Brook 60521
William M. Lees, *Vice-Chairman*
(*Chairman, Board of Trustees*)
6518 N. Nokomis Ave., Lincolnwood 60646
Willard C. Scrivner
(*President*)
Suite #2, 6600 W. Main St., Belleville 62203
Fredric D. Lake
(*President-Elect*)
1041 Michigan Avenue, Evanston 60202

Frank J. Jirka, Jr.
(*Immediate Past-President*)
1507 Keystone Ave., River Forest 60305
George T. Wilkins
(*Chairman, Governmental Affairs Council*)
3165 Myrtle, Granite City 62040

Marshall A. Falk
(*Chairman, Council on Mental Health and Addiction*)
4700 N. Clarendon, Chicago 60640

STAFF: Richard Ott

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, *Chairman*
102 E. Market, Havana 62644
Jack Gibbs
175 S. Main St., Canton 61520
Charles Salesman
1 Laurel Lane, Paris 61944
CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704

STAFF: Perry L. Smithers

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

INA-ISMS JOINT PRACTICE COMMITTEE

Bernard Adelson
595 Lincoln, Glencoe 60022
Joseph L. Bordenave
1665 South St., Geneva 60134

J. M. Ingalls
502 Shaw, Paris 61944
Fred Z. White
723 N. 2nd St., Chillicothe 61523
STAFF: Philip G. Thomsen II

OTHER REPRESENTATIVES

SWANBERG FOUNDATION, QUINCY
Arkell M. Vaughn
9012 S. Leavitt, Chicago 60620
HEALTH CAREERS COUNCIL OF ILLINOIS (HCCI)
Allan Goslin
712 N. Bloomington, Streator 61364
MIDWEST REGIONAL LIBRARY ASSOCIATION
H. Close Hesseltine
5807 S. Dorchester, Chicago 60637
LIAISON TO ILLINOIS SOCIETY OF THE AMERICAN
ASSOCIATION OF MEDICAL ASSISTANT
Carl E. Clark
225 Edward St., Sycamore 60178
ILLINOIS COUNCIL OF HOME HEALTH AGENCIES
Herman J. Nebel
632 Vogel Place, East St. Louis 62205
COUNCIL ON EFFICIENCY OF HEALTH CARE
Eugene Johnson
P.O. Box 68, Casey 62420
James Laidlaw
1005 Lincolnshire, Champaign 61820
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
Fred A. Tworoger
4753 Broadway, Chicago 60640
CHICAGO ALLIANCE FOR VD AWARENESS
Edward Piszczek
6410 N. Leona, Chicago 60646
DRUG ABUSE COUNCIL OF ILLINOIS
George Shropshear
1525 E. 53rd St., Chicago 60615

Joseph Skom
707 N. Fairbanks Ct., Chicago 60611
JOINT COMMITTEE ON SCHOOL HEALTH
Richard Dukes
612 W. University, Urbana 61801
W. W. Fullerton
101 N. Market, Sparta 62288
PEDIATRIC COORDINATING COUNCIL
Daniel Pachman
1212 N. Lake Shore Dr., Chicago 60605
ILLINOIS INTERAGENCY COUNCIL ON SMOKING & DISEASE
Vacant
IDPH/CHP Ad Hoc PLANNING COMMITTEE ON
PERINATAL MORTALITY
Robert R. Hartman
1515 W. Walnut, Jacksonville 62650
William R. Larsen
13707 W. Jackson, Woodstock 60098
U.S. PHARMACOPOEIA
Joseph Skom
707 N. Fairbanks Ct., Chicago 60611
BAR ASSOCIATIONS INTERPROFESSIONAL CODE
Donald D. O'Sullivan
411 W. Dickens, Chicago 60614
David T. Petty
30 N. Michigan, Chicago 60602
Constantine Veremakis
409 E. Park Dr., Belleville 62223
Herman Wing
836 W. Wellington, Chicago 60657

ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S.

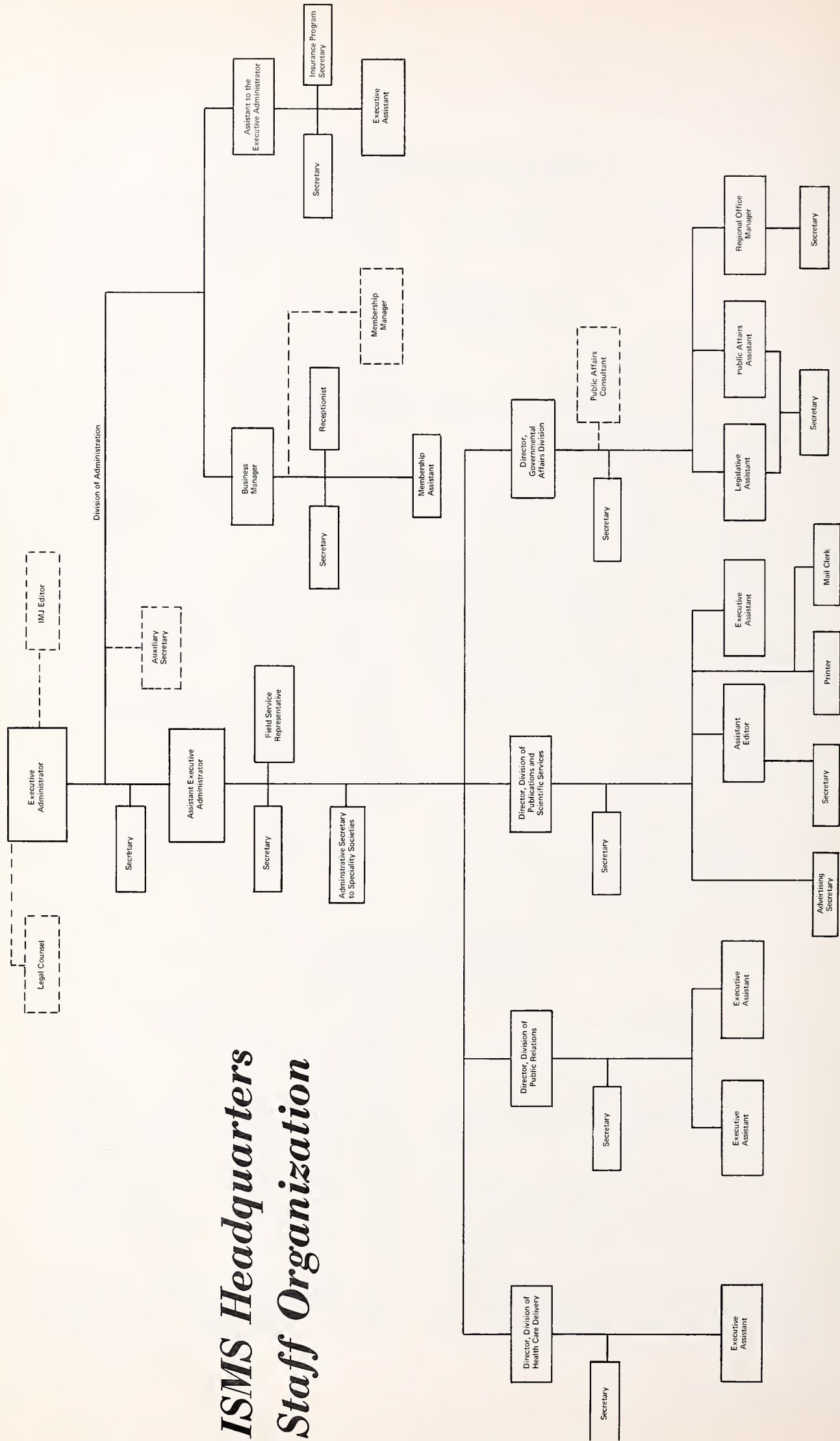
Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications and Scientific Services; and Health Care Delivery.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

ISMS Headquarters Staff Organization



DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with

the best professional staff services available, headquarters has been set up by divisions.

The Assistant Executive Administrator serves within this Division as a coordinator for the programs operated by other Divisions. Further coordination between the programs of the State Society and the County Medical Societies is achieved through a Field Services Representative working under the direction of the Assistant Executive Administrator.

The Society sponsored insurance programs, benevolence programs, travel tours for members, physician placement programs, student loan fund program and all activities concerning the annual meeting are handled within the Division by the Assistant to the Executive Administrator.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legisla-

ture is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

The division also staffs the committees on Public Affairs, Eye Health, Forensic Medicine, and Legal Definition of Death.

DIVISION OF HEALTH CARE DELIVERY

The Division of Health Care Delivery was established because of the many important and complex socio-economic issues currently facing medicine.

A primary responsibility of the division is keeping ISMS members abreast of these socio-economic issues which have

such impact on the delivery of health care. The division has expanded its activities in researching the many new types of health care programs being proposed or in varying stages of development throughout the state. Such pertinent socio-economic information will be disseminated

to ISMS members through articles in the *Illinois Medical Journal* and "Action Report," and through special programs. During the past year the division has also worked closely with the Illinois Foundation for Medical Care.

The division staffs the Council on Economics & Peer Review and its committees on Peer Review Appeals and Relative Value Study. Principle duties of the council concern relations with the health insurance industry, government health programs, Comprehensive Health Planning agencies and regional medical programs. The Peer Review Appeals Committee serves as the appellate body for all disputed cases initially considered by local or district peer review committees. The Relative Value Study Committee's task is to study the feasibility of developing or updating an Illinois relative value study.

During the year, the Division assumed the staffing

duties for the Council on Social and Medical Services. This council initiates and implements programs related to health care facilities, hospital services, and emergency room and disaster medical care. It also maintains liaison with other health related organizations such as vocational rehabilitation, aging, health care of the poor, and rural health. Committees of the Council on social and medical services include: Health Care of the Poor and Rural Problems, Emergency and Disaster Care, and Hospital Satellites.

In addition, the division staffs the Committee on Governmental Health Program Reimbursement which serves as liaison to Medicare, Medicaid and CHAMPUS in any matters regarding physician reimbursement by these programs. Finally, the Division of Health Care Delivery attends the Illinois Department of Public Aid's Medical Advisory Committee as an observer.

DIVISION OF PUBLIC RELATIONS and MEMBERSHIP SERVICES

The Division of Public Relations functions both as a news outlet to the media and as a source of information to the membership.

Staff members prepare speeches and produce pamphlets and other materials on a wide variety of medical topics. They serve as consultants on public relations and publicity to county societies and also maintain liaison with state and private agencies in the health field and with allied associations.

The division is contacted almost daily by medical and scientific news writers who are obligated to provide timely information to a public that is increasingly interested in the many phases of health care.

The proliferation in recent years of health agencies at every level of government has brought the additional staff duty of "keeping up" with the activities of these agencies and reporting to the membership.

Beyond these traditional public relations duties, the division has initiated a number of special and highly successful projects. A few of them are:

Journalism Awards . . . are given annually for "distinguished achievement in medical journalism" in a variety of categories covering all media. The presentation program is thoroughly professional and the winners value the awards as a sincere recognition of their own efforts to inform the public.

President's Tour . . . takes the President of ISMS to each of the 11 Districts and gives him a chance to meet and discuss medical matters with physicians throughout the state. The president also holds press conferences and visits local media for interviews during the tour.

Action Report . . . is a publication which keeps members informed of current developments on such vital issues as malpractice problems and PSRO. The report also covers legislative and socio-economic events affecting the livelihood of all physicians.

Dr. Sims Health Tips . . . provide Illinois radio stations with a series of health tips for use seven days a week all year. "Dr. Sims Talks to Teens" is a monthly column on health advice printed in more than 400 high school newspapers.

Radio-TV Speakers Bureau . . . obtains physician speakers for discussion of general medical subjects, or for special interviews on critical issues of the day.

Legislator TV Interviews . . . supplies the state's TV stations during sessions of the General Assembly with sound-on-film segments of the views of legislators on pending health bills. This accomplishes the triple purposes of publicizing ISMS; establishing contacts with key TV station personnel; and maintaining good relationship with the legislators involved.

DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

The Division of Publications and Scientific Services is charged with staff responsibility for a variety of activities. This is evidenced by Council and Committee assignments, to wit: Council on Education and Manpower, Council on Environmental and Community Health, Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils listed above are several committees and sub-committees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's re-

sponsibility, except for distribution of items to selected specific groups. All printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding. Modern reproduction and collating equipment allows for professional, commercial-quality production.

In addition, all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinets. Mailings are accomplished through computer-supplied labels and the addressograph.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and

social developments within the state, as such pertain to the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Advertising

Commercial advertising is carried within the *Illinois Medical Journal*. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. These are accomplished through an adver-

tising department and ISMS representatives. This furnishes opportunity of presenting a product to members of ISMS through advertising in ISMS publications.

Educational and Scientific Services

As is apparent from the list of councils of ISMS for which staff responsibility is assigned, there is a multiplicity of activity. Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. An ongoing scheduling of meetings of ISMS' committees provides opportunity for addressing the many concerns of medical practice today. The division, in addition, attempts to have expert information available to the members.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

FILM

Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for any physician faced with the management of

multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identity was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

SPECIAL PUBLICATIONS

Action Report

"Action Report" is a bi-weekly newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made by ISMS.

On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request to the select list developed for "Action Report." It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending physician forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms re-

ceived. Each physician has been asked to voluntarily adopt the following procedure:

- 1) When a physician receives a form from an insurance company bearing the HIC symbol it should be completed and returned to the company.
- 2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.
- 3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations.

Hospital Disaster Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing disaster plans, ISMS has adopted a model plan for hospitals.

Originally developed by the Memorial Hospital

of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the Society.

Oral Contraceptive Forms

Legal consent forms for use when dispensing birth control pills are now available to ISMS members. ISMS Trustees asked that the forms be prepared and made available because of adverse court decisions against physicians prescribing the pill.

Use of the consent forms is optional with each physician.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a

roster containing the names of more than 400 speakers and over 1,000 topics.

- 2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the Scientific Speakers Bureau, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

- 3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

- 4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

- 5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 575 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 100 "open" areas needing physicians.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois Department of Public Health and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact

the service.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians—through the Doctor's Job Fair held annually.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. Loan installments are made twice a year. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student

Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

- (1) Freshman student receiving recommendation—five years of practice.
- (2) Freshman student receiving financial assistance for four years—four years of practice.
- (3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select of practice location of his own choice, provided it is in a community that has demonstrated a physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college admissions test; and that his college grade transcript be submitted with the completed application form. Student applying to this program for a recommendation must complete an official application for admission to the University of Illinois by November 1. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance

are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Secretary, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 901, Bloomington, IL 61701.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September, 1961.

Illinois is distinguished in this matter by being the only state which has a court rule permitting

the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

INSURANCE PROGRAMS

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the Retirement Investment Program which makes available to members a means of providing for retirement with group advantages that an individual physician could not otherwise obtain. The Retirement Investment Program provides for balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing so, he not only receives advantages he would not otherwise have, but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The Retirement Investment Program, making available the group annuity at a substantial reduction in premium, and the mutual funds, is one of the most recent of its kind. This program was developed after several years of study taking into consideration other group plans and retirement

alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

Mutual Fund

The open end mutual fund consisting primarily of common stocks is Massachusetts Investors Growth Stock Fund Inc. The assets of the fund are over one billion dollars. Its' sister fund, Massachusetts Investors Trust, is the nation's oldest mutual fund. The Growth Fund is offered with an 8½% sales charge and the Investment Adviser, Massachusetts Financial Services Inc., receives an investment advisory fee of .09% per annum. The fund is quoted daily in most major newspapers including the *Wall Street Journal*.

Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the Society's Tax-Qualified Retirement Program, which utilizes a Continental Assurance Company Group Annuity and the Massachusetts Investors Growth Stock Fund. This program is intended for members who may find the provisions of the Keogh Act to their advantage as it allows contributions made by self-employed physicians to be fully deductible. The principal pro-

visions of the Keogh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or \$2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full-time employees with three or more years service under the Plan. A full-time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

National Boulevard Bank of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physician's contributions and maintains the Program's records.

Members who are incorporated, or are considering incorporation, may wish to receive the information pertaining to the Illinois State Medical Society IRS approved Corporate Pension and Profit Sharing Plans. This information, together with the information pertaining to the ISMS Retirement Investment Program or the Keogh Act Program, may be obtained by writing the Plan Administrator: Robinson Inc., Administrator, ISMS Retirement Programs, 209 South LaSalle Street, Chicago 60604.

Hospital Income Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays \$25 in cash (Plan A) or \$50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to \$9,125 (Plan A) or \$18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson-Kirke Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance,

coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Benefit Plan was made available to the membership and was received very well. During enrollment periods all members regardless of age could participate. Enrollment periods are anticipated every 12 to 18 months.

Group Disability Program

The Illinois State Medical Society's officially approved Group Disability Program is available to all eligible members of ISMS up to age 60 who are regularly attending all of the usual duties of their occupation and is renewable to age 70. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$100 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society headquarters.

Business Overhead Expense Group Plan

Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office

open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$2500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1)

month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitutes business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.S. 1955-19, p. 8.).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

Professional Liability Program

A new professional liability insurance program became available to members of the Illinois State Medical Society June 1, 1973. Underwritten by the Hartford Insurance Group and administered by Johnson and Higgins, Inc., the program requires the active involvement of physicians in claims and underwriting procedures. Through medical review committees operating in each ISMS district, the insurance company receives recommendations on the best course of action to be taken to protect the program and still be responsive to the individual physician's needs.

The program covers physicians and surgeons for

alleged malpractice claims arising from professional acts or omissions. Limits of \$1 million, \$2 million, \$5 million or \$100,000/\$300,000 are available. Corporations and partnerships may be covered for an additional premium if each member is insured for a minimum of \$1 million.

Optional personal excess liability protection is also available.

To facilitate premium payments, a standard quarterly billing cycle has been established.

Full details and application forms may be obtained from ISMS or Johnson & Higgins, 101 S. Wacker Dr., Chicago 60604; phone 312-236-3491.

Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$200,000. Features of the program include guaranteed future purchase options, guar-

anteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

Ancillary Organizations

Woman's Auxiliary

To The Illinois State Medical Society

The theme, *Ad Astra per Aspera* (To the Stars Through Aspirations) has not created an "impossible dream" for the Woman's Auxiliary to the Illinois State Medical Society. Following our annual convention in March, 1973, we launched into the formulation of plans for the year's activities with enthusiasm. Goals were established by individuals, by county groups and by the State Board of Directors, and recorded in a new "How To and Who" manual, loose-leafed for additions or deletions, this book was distributed at the convention to Board members and County Presidents. Through a monthly letter Board members and County Presidents are being assisted in reaching their goals using inspirational and informative tools or guidelines.

In June, nine delegates, the presidential delegates and one alternate represented Illinois at the national convention of the Woman's Auxiliary to the American Medical Association. At the national convention interesting reports were heard, the national By-laws were revised, and projections and programs were presented for the year 1973-74. Illinois was honored to have Mrs. Willard C. Scrivner, of Belleville installed as national president.

A summer Board meeting was held, July 9, in Chicago, at which time the delegates to the national convention gave their report and regular Board business was conducted. This summer Board meeting enabled chairmen to obtain quick and complete information, which they, in turn, will pass on to County Presidents. Upon the resignation of Mrs. Franklin Yoder as President-Elect, Mrs. Thomas Glatter of Rockford was appointed "Acting" President-Elect. Since Mrs. Glatter is also membership chairman, it is felt she will strengthen our goals in her double capacity.

This fall a *Pulse* will be published. This organ will be released four times a year and will go to our entire membership through the generosity of the Illinois State Medical Society.

Visits to the county auxiliaries are uppermost in the plans for, the president and president-elect, during this fall.

Our Auxiliary was represented at a Communications Symposium held in Champaign, September 12, and sponsored by the Illinois Hospital Association. Early October offers the annual Fall Conference for presidents and presidents-elect, a four-day conference in Chicago, and also attended by our Executive Secretary. October 18 and 19 are the dates for the North Central Regional Workshop (12 states), held in Cincinnati, Ohio, with seven of our Board members in attendance.

The highlights of November are the district meetings to be held as follows: Belleville, November 8 (districts 9 and 10), Springfield, November 12 (districts 2, 4, 5, 6, 7, and 8), and Chicago, November 13 (districts 1, 2, and 11). A "health search" will be conducted throughout the state prior to these meetings and a feature of all the district meetings will provide an opportunity for discussion of health needs of the various districts.

We will be privileged to join with the Illinois State Medical Society in the launch of a co-sponsored Health Education Conference, February 28, 1974, at the LaSalle Hotel, in Chicago, and also to participate with the ISMS in a Legislative Day in Springfield, May 8, 1974. Many members will be interested and involved in the Washington Roundup, February 3-6, 1974, and in the Quality of Life Congress on Aging, sponsored by the American Medical Association and the Woman's Auxiliary to the American Medical Association, April 1, 2 and 3, 1974, followed by our own annual convention.

Our goals have been set and guidelines established. Much groundwork has been laid, and our year promises new achievements and new discoveries.

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WA/ISMS President

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American Association of Medical Assistants Illinois Society

Membership in the Illinois Society, American Association of Medical Assistants is open to all persons employed by physicians in administrative and clinical categories. Membership includes nurses, technicians, secretaries, book-

keepers, clerks and aides. The Society's objectives are to: (a) maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (b) assist the

physicians in improving medical public relations; (c) bring into one association all medical assistant organizations of the state of Illinois; (d) provide an organization for those residing in Illinois counties where no medical assistant societies are organized; and (e) meet occasionally for interchange of ideas.

Medical Assistants joint together to form component county chapters of Illinois Society, AAMA; there are active chapters in the following counties: Cook (Chicago, Cook South and Northwest Cook), Kane, Lake, McHenry, Kankakee, Vermillion, DuPage, DeKalb, Will-Grundy, Peoria, Macon, Sangamon, Williamson-Jackson-Franklin, St. Clair, Jefferson-Hamilton, Rock Island, Stephenson, Fulton, McLean, LaSalle, Henry-Stark, Iroquois, Morgan-Scott and McDonough.

Local county societies and the Illinois Society conduct numerous activities and programs to educate and inform members. Major program at the state level include: (1) "traveling courses" held throughout the state; (2) a symposium each September; (3) area meetings in conjunction with the ISMS President's Tour; (4) three-day annual meeting in April; (5) publication of a newsletter, "Executive Memo", which keeps members up to date on AAMA activities; and (6) publication of a quarterly journal, *The Illini Cardinal*.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully completing the special board examination and meeting qualifying criteria of this American Association of Medical Assistants certification program. For further information of this program write to the American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago 60601.

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The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

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Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison

between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of

Osteopathic Physicians & Surgeons also plans to offer financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical Society and the state's medical schools; and (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities:

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The first Congress met April 19, 1973, the first assemblage of Illinois physicians to identify desirable CME goals and methods to achieve those goals, from the physician's viewpoint. (For a copy of the First Congress Report, just write "1973 Congress Report" on your prescription blank, and mail to: ICCME, 360 N. Michigan Ave., Chicago, IL 60601.)
2. On behalf of ISMS, perform staff work for accreditation

tion of intra-state CME.

3. Advise hospitals and other organizations on effective CME methods.
4. Organize training sessions on CME methods for Directors of Medical Education and Program Chairmen.
5. Distribute a pamphlet, *Your Personal Learning Plan*, offering advice on how to plan your learning most effectively. Every Illinois physician—M.D. or D.O.—may receive a copy free upon request; just write "Personal Learning Plan" on your prescription form, and mail to ICCME (*see* address under 1, *above*). To all others, the cost is \$1.00/copy, postpaid.
6. Maintain a map of Illinois, plus detailed data, showing distribution of physicians and health institutions pertinent to state-wide CME planning.
7. Maintain and publish a calendar of Illinois CME activities.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

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Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care is a physician-member, not-for-profit corporation established in July, 1971, at the request of the ISMS House of Delegates. Through the Foundation, physicians retain the prerogatives of medical determinations and have direct participation and leadership in the design, implementation and administration of various health care programs.

Since its implementation in February, 1972, the Hospital Admission and Surveillance Program (HASP), a program of the Foundation, has certified the medical necessity and

length-of-stay for more than 355,000 Medicaid admissions, as of September, 1973. Based on data compiled on these HASP admissions, IFMC physician-member committees have adjusted the lengths-of-stay in the 20 top admitting-diagnosis categories.

Several local foundations have affiliated with the Illinois FMC: Chicago FMC, Northern Illinois FMC, Quad River FMC, Champaign County Foundation for Health Care and the Western Illinois FMC. The newest of these affiliates, WIFMC, has commercially contracted to perform admis-

sions and length-of-stay certification for the Motorola Corporation. Physicians in other areas of Illinois are utilizing the assistance and cooperation of IFMC toward forming their own local foundations.

Membership in IFMC is available to any licensed physi-

cian or osteopath qualified to practice medicine in all its branches. In affiliated local foundation areas, IFMC membership is contingent upon membership in the local FMC. Information can be obtained by writing IFMC, 360 No. Michigan Ave., Suite 1418, Chicago, 60601.

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Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Con-

gress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

Medical and Paramedical Education

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School

2020 W. Ogden Ave., Chicago, 60612

Northwestern University Medical School

303 E. Chicago Ave., Chicago, 60611

University of Chicago-Pritzker School of Medicine

950 E. 59th Street, Chicago, 60637

University of Illinois College of Medicine

1853 W. Polk Street, Chicago, 60680

Abraham Lincoln School of Medicine, Chicago

Metropolitan Hospital Group, Chicago

Peoria School of Medicine, Peoria

Rockford School of Medicine, Rockford

School of Associated Medical Sciences, Chicago

School of Basic Medical Sciences, Chicago

School of Basic Medical Sciences, Urbana

Loyola University, Stritch School of Medicine

2160 S. First Ave., Maywood, 60153

Rush Medical College

1725 W. Harrison St., Chicago 60612

Southern Illinois University Medical School

901 N. First St., P.O. 3926, Springfield, 62708

PARAMEDICAL EDUCATION

APPROVED SCHOOLS FOR MEDICAL RECORD TECHNICIAN

EAST PEORIA—Illinois Central College
PALOS HILLS—Moraine Valley Community College

APPROVED SCHOOL FOR MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOLS OF RESPIRATORY (INHALATION) THERAPY

CHICAGO—Cook County Hospital, Rush-Presbyterian-St. Luke's Medical Center, University of Chicago Hospital, Veterans Administration Hospital, Luthern Hospital, Northwestern University Medical Center

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—St. Anthony Hospital

SPRINGFIELD—Memorial Hospital

APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ARLINGTON HEIGHTS—Northwest Community Hospital

CHICAGO—St. Elizabeth Hospital, Swedish Covenant Hospital, Veterans Administration West Side Hospital

CRYSTAL LAKE—McHenry County College

DANVILLE—St. Elizabeth Hospital

DIXON—Sauk Valley Junior College

ELGIN—Sherman Hospital

OAK PARK—Oak Park Hospital

QUINCY—Blessing Hospital

OLNEY—Richland Memorial Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Medical Center, Mount Sinai Medical Center, University of Chicago Hospitals and Clinics

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

BELLEVILLE—St. Elizabeth Hospital

BLUE ISLAND—St. Francis Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Augustana Hospital Health Care Center, Chicago Medical School/University of Health Sciences, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Medical Center, Louis A. Weiss Memorial Hospital, Mercy Hospital & Medical Center, Michael Reese Hospital & Medical Center, Northwestern Memorial Hospital, Rush-Presbyterian-St. Luke's Medical Center, St. Anne's Hospital, St. Anthony Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois at the Medical Center, Veterans Administration Research Hospital.

CHICAGO HEIGHTS—St. James Hospital

DANVILLE—Lake View Memorial Hospital

DECATUR—Decatur Memorial Hospital and St. Mary's Hospital

EVANSTON—Evanston Hospital, St. Francis Hospital

FREEPORT—Freeport Memorial Hospital

GENEVA—Community Hospital

GREAT LAKES—U.S. Naval Hospital

HARVEY—Ingalls Memorial Hospital

HINSDALE—Hinsdale Sanitarium and Hospital

JOLIET—Silver Cross Hospital, St. Joseph Hospital

MAYWOOD—Loyola University Center

OAK LAWN—Christ Community Hospital, West Suburban Hospital Association

PARK RIDGE—Lutheran General and Deaconess Hospitals

PEORIA—Methodist Hospital of Central Illinois and St. Francis Hospital

QUINCY—St. Mary's Hospital

ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital

SPRINGFIELD—Springfield Memorial Hospital, St. John's Hospital

URBANA—Carle Foundation Hospital

WAUKEGAN—St. Therese's Hospital

WINFIELD—Central Dupage Hospital

APPROVED SCHOOLS FOR NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital

HINES—Veterans Administration Hospital

APPROVED SCHOOL FOR RADIATION THERAPY TECHNOLOGISTS

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center Hospital

APPROVED EDUCATIONAL PROGRAMS FOR HISTOLOGICAL TECHNICIAN

CHICAGO—St. Joseph Hospital, University of Chicago Hospital & Clinics

APPROVED EDUCATIONAL PROGRAMS FOR RADIOLOGIC TECHNOLOGISTS

ARLINGTON HTS.—Northwest Community Hospital
 AURORA—Copley Memorial Hospital
 BELLEVILLE—Belleville Area College
 BLOOMINGTON—Bloomington-Normal School X-ray
 Technology
 CENTRALIA—St. Mary's Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Cook County Hospital
 De Paul University
 Edgewater Hospital
 Englewood Hospital
 Forkosh Memorial Hospital
 Franklin Boulevard Community Hospital
 Henrotin Hospital
 Illinois Masonic Medical Center
 Louis A. Weiss Memorial Hospital
 Malcolm X Community College
 Michael Reese Hospital and Medical Center
 Mt. Sinai Hospital and Medical Center
 Northwestern Memorial Hospital
 Provident Hospital and Training School
 Ravenswood Hospital
 Roseland Community Hospital
 Rush-Presbyterian-St. Luke's Medical Center
 St. Anne's Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital
 University of Illinois Hospital
 Woodlawn Hospital
 DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur Memorial Hospital
 DIXON—Sauk Valley College

EAST ST. LOUIS—Centreville Township Hospital and
 Belleville Area College
 ELGIN—St. Joseph Hospital
 ELMHURST—Memorial Hospital of Du Page County
 EVANSTON—St. Francis Hospital
 Evanston Hospital
 GALESBURG—Carl Sandburg College
 GLEN ELLYN—College of DuPage
 HINSDALE—Hinsdale Sanitarium and Hospital
 JOLIET—Silver Cross Hospital
 St. Joseph Hospital
 KEWANEE—Kewanee Public Hospital
 MACOMB—McDonough District Hospital
 MALTA—Kieshwaukee Junior College
 MOLINE—Lutheran Hospital
 Moline Public Hospital
 OAK PARK—West Suburban Hospital
 OLNEY—Richland Memorial Hospital
 PALOS HILLS—Moraine Valley Community College
 PEORIA—Methodist Hospital of Central Illinois
 St. Francis Hospital
 QUINCY—Blessing Hospital
 St. Mary's Hospital
 RIVER GROVE—Triton College
 ROCKFORD—Rockford Memorial Hospital
 St. Anthony Hospital
 Swedish-American Hospital
 ROCK ISLAND—St. Anthony's Hospital
 SKOKIE—Skokie Valley Community Hospital
 SOUTH HOLLAND—Thornton Community College
 SPRINGFIELD—Springfield Memorial Hospital
 St. John's Hospital,
 Lincoln Land Community College

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

BELLEVILLE	
Belleville Area College Department of Nursing 2555 West Blvd.	62221
CENTRALIA	
Kaskaskia College Department of Nursing Shattuc Road	62801
CHICAGO	
Amundsen-Mayfair College Department of Nursing 4626 N. Knox Ave.	60630

Kennedy-King College Department of Nursing 7047 S. Stewart	60621	OGLESBY Illinois Valley Community College Department of Nursing R.R. #1	61348
Malcolm X. College Department of Nursing 1900 W. Van Buren	60621	OLNEY Olney Central College of Eastern Illinois 305 N. West St.	62450
Olive Harvey College Department of Nursing 10001 S. Woodlawn	60628	PALATINE William Rainey Harper College Department of Nursing Algonquin & Roselle Roads	60067
CHICAGO HEIGHTS Prairie State College Department of Nursing 157th & Halsted	60411	PALOS HILLS Moraine Valley Community College Department of Nursing 10900 S. 88th Ave.	60465
CHAMPAIGN Parkland College, Dept. of Nursing 2 Main Street	61820	RIVER GROVE Triton College Department of Nursing 2000 N. Fifth Avenue	60171
CICERO J. Sterling Morton Junior College Department of Nursing 2500 S. Ashland Blvd.	60650	ROCKFORD Rock Valley College Department of Nursing Rockford	61101
DIXON Sauk Valley College, Dept. of Nursing River Campus, R.R. #1	61021	SOUTH HOLLAND Thornton Community College Department of Nursing 50 W. 162nd St.	60473
EAST PEORIA Illinois Central College Department of Nursing Highview Road, P.O. Box 2400	61611	SPRINGFIELD Lincoln Land Community College Department of Nursing 3865 S. 6th Frontage Road	62703
EAST ST. LOUIS State Community College Department of Nursing 417 Missouri Ave.		SUGAR GROVE Waubonsee College Department of Nursing Rt. 47 Harter Road, P.O. Box 508	60554
ELGIN Elgin Community College Department of Nursing 1700 Spartan Drive	60120		
GALESBURG Carl Sandburg College Department of Nursing Box 1407	61401		
GLEN ELLYN College of DuPage Department of Nursing 22nd & Lambert Road	60137		
GODFREY Lewis & Clark Community College Department of Nursing Godfrey	62035		
GRAYSLAKE Lake County College Department of Nursing 19351 West Washington	60030		
JOLIET Joliet Junior College Department of Nursing Route #3 Houbolt Ave.	60436		
KANKAKEE Kankakee Community College Department of Nursing Box 888	60901		
MOLINE Black Hawk College Department of Nursing 6600 34th Ave.	61265		

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately \$1,000 to \$7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

BLOOMINGTON

Brokaw Collegiate School of Nursing
of Wesleyan University 61701

CHICAGO

DePaul University
Department of Nursing
2323 N. Seminary 60614

Loyola University
Department of Nursing
6526 N. Sheridan Rd. 60626

North Park College
Department of Nursing
5125 N. Spaulding Ave. 60625

Rush College of Nursing
and Allied Health Services
1725 W. Harrison St. 60612

St. Xavier College
Department of Nursing
103rd & Central Park 60655

University of Nursing
College of Nursing
P.O. Box 6998
845 S. Damen 60612

DEKALB

Northern Illinois University
Department of Nursing 60115

EDWARDSVILLE

Southern Illinois University
Edwardsville Campus
Department of Nursing 62025

ELMHURST

Elmhurst College
Department of Nursing 60126

KANKAKEE

Olivet Nazarene College
Department of Nursing 60901

LOCKPORT

Lewis College
School of Nursing 60441

PEORIA

Bradley University
Department of Nursing 61606

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: \$900 to \$3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

ALTON

Alton Memorial Hospital
Memorial Drive 62002

St. Joseph's School
915 E. Fifth St. 62035

AURORA

Copley Memorial Hospital
Lincoln & Weston 60507

BLOOMINGTON

Mennonite Hospital
804 N. East St. 61701

CANTON

Graham Hospital
210 W. Walnut St. 61520

CHICAGO

Augustana Hospital
427 Dickens Ave. 60614

Cook County School of Nursing
1900 W. Polk St. 60612

Illinois Masonic Hospital
836 Wellington Ave. 60657

Michael Reese Hospital	
2816 S. Ellis Ave.	60616
Mount Sinai Hospital	
2730 W. 15th Place	60608
Northwestern Memorial Hospital	
Wesley-Passavant School of Nursing	
Superior and Fairbanks Court	60611
Ravenswood Hospital	
1931 W. Wilson Ave.	60640
St. Anne's Hospital	
4950 W. Thomas St.	60651
St. Bernard's Hospital	
6344 S. Harvard Ave.	60621
St. Mary of Nazareth	
1127 N. Oakley Blvd.	60622
South Chicago Community Hospital	
2320 E. 93rd St.	60617
DANVILLE	
Lake View Memorial Hospital	
812 N. Logan Ave.	61832
DECATUR	
Decatur Memorial Hospital	
2300 N. Edward St.	62526
EVANSTON	
Evanston Hospital Nursing Program	
2645 Girard Ave.	60201
St. Francis Hospital	
319 Ridge Ave.	60202
FREEPORT	
Freeport Memorial Hospital	
1133 W. Stephenson	61032
JACKSONVILLE	
Passavant Memorial Area Hospital	
1600 W. Walnut St.	62650
JOLIET	
St. Joseph Hospital	
333 N. Madison St.	60435
MOLINE	
Lutheran Hospital	
555 Sixth St.	61265
Moline Public Hospital	
635 Tenth Avenue	61265
OAK LAWN	
Evangelical School of Nursing	
4440 W. 95th St.	60453
OAK PARK	
West Suburban Hospital	
518 N. Austin Blvd.	60302
PARK RIDGE	
Lutheran General and Deaconess Hospitals	
1775 Dempster St.	60068
PEORIA	
Methodist Hospital of Central Illinois	
221 N.E. Glen Oak	61603
St. Francis Hospital	
211 Greenleaf St.	61609

QUINCY	
Blessing Hospital	
1005 Broadway	62301
ROCKFORD	
Rockford Memorial Hospital	
2400 N. Rockton Ave.	61103
St. Anthony Hospital	
5658 E. State St.	61101
Swedish-American Hospital	
1316 Charles St.	61101
ROCK ISLAND	
St. Anthony Hospital	
767 Thirtieth St.	61201

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

Entrance Requirements:

Good health.

High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.

Satisfactory results on entrance tests.

References and personal interview.

Cost: None under MDTA programs, to approximately \$400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

ALTON

F. W. Olin School of Practical Nursing
2512 Amelia Street 62002

BLOOMINGTON

Bloomington School of Practical Nursing
709 S. Clinton St. 61701

CANTON

Spoon River School of Practical Nursing

CARTERVILLE

Practical Nursing Program, Logan College

CHAMPAIGN	504 E. Court St.	62650
Champaign School of Practical Nursing		
103 N. Prospect Ave.	61821	
Practical Nursing Program, Parkland College		
Champaign	61820	
CHICAGO		
Chicago Public Schools Practical Nursing Center		
1820 W. Grenshaw	60612	
Chicago Public Schools Licensed Practical Nurses Program, Manpower Division		
2913 N. Commonwealth	60657	
St. Frances X. Cabrini School of Practical Nursing		
811 S. Lytle St.	60607	
DANVILLE		
Danville School of Practical Nursing		
200 E. Main	61832	
DECATUR		
Decatur School of Practical Nursing		
210 W. North St.	62521	
DE KALB		
Kishwaukee School of Practical Nursing		
612 Haish Blvd.	60115	
DIXON		
Sauk Valley College		
River Campus Route #1	61021	
EAST PEORIA		
Illinois Central College Practical Nursing Program, Health Education		
P.O. Box 2400	61611	
EAST ST. LOUIS		
School of Practical Nursing		
910 Summit	62201	
GALESBURG		
Carl Sandburg College, Department of Practical Nursing		
Box 1407, South Lake Storey Road	61401	
GRAYSLAKE		
Lake County College Practical Nurse Program		
19315 Washington Street	60030	
HARRISBURG		
Southeastern Illinois College, School of Practical Nursing		
333 W. Church St.	62946	
HARVEY		
Thornton Community College, Department of Practical Nursing		
150th Broadway	60426	
HINSDALE		
Hinsdale Hospital School of Practical Nursing		
120 N. Oak St.	60521	
JACKSONVILLE		
Jacksonville Board of Education School of Practical Nursing		
JOLIET		
Joliet Township H.S.		
School of Practical Nursing		
201 E. Jefferson St.	60432	
KANKAKEE		
Kankakee School of Practical Nursing		
Kankakee Community College		
Box 888	60901	
LASALLE		
St. Mary's Hospital		
School of Practical Nursing		
1015 O'Connor St.	61301	
MATTOON		
Lake Land College		
School of Practical Nursing		
1921 Richmond	61938	
MOLINE		
Black Hawk College		
6600-34th Ave.	61265	
MORTON GROVE		
Oakton Community College		
7900 N. Nagle	60053	
MT. CARMEL		
Wabash Valley College		
Practical Nursing Program		
2200 College Dr.	63863	
MT. VERNON		
Rend Lake College		
Practical Nursing Program		
PALATINE		
William Rainey Harper		
Practical Nursing Program		
Algonquin & Roselle Roads	60067	
QUINCY		
Quincy School of Practical Nursing		
820 Vermont Street	62301	
RIVER GROVE		
Triton Junior College		
Practical Nursing Program		
2000 N. Fifth Ave.	60171	
ROCKFORD		
Rockford School of Practical Nursing		
201 S. Madison	61101	
SPRINGFIELD		
Springfield School of Practical Nursing		
1101 S. 15th St.	62704	
STREATOR		
Streator Township High School		
Practical Nurse Program		
600 N. Jefferson	61364	
ULLIN		
Shawnee Community College		
Department of Nursing		
Shawnee College Road	62992	

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 2 and 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Repre-

sentatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out

the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield 62701.

STATE OFFICERS

Governor, DANIEL WALKER, Dem., Chicago
Lieutenant Governor, NEIL F. HARTIGAN, Dem., Chicago
Secretary of State, MICHAEL J. HOWLETT, Dem., Chicago
Comptroller, GEORGE W. LINDBERG, Rep., Crystal Lake

State Treasurer, ALAN DIXON, Dem., Belleville
Attorney General, WILLIAM J. SCOTT, Rep., Evanston
Superintendent of Public Instruction, MICHAEL BAKALIS, Dem., DeKalb
Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Room 1713, 160 N. LaSalle St., Chicago
524 South Second St., Springfield
Jerome G. Miller, *Director*

Director's Office

Dolores Reid, Deputy Director, Program Services
John Lambert, Deputy Director, Management Services
Jerome Stermer, Administrative Assistant to the Director
Kenneth Guza, Administrative Assistant to the Director
Thomas A. Nickell, Administrative Assistant to the Director
Richard S. Laymon, Guardianship Administrator
Frank Kopecky, Technical Advisor

Office of Community Relations

524 South Second St., Springfield
Donald H. Schlosser, *Administrator*

Office of Program Development

Room 200, 160 N. LaSalle St., Chicago
Bruce Thomas, *Director*

Office of Affirmative Action

Room 1713, 160 N. LaSalle St., Chicago
Robert N. Thayer, *Administrator*

Office of Education and Rehabilitation

524 South Second St., Springfield
Lee A. Iverson, *Director*
Everett E. Hamilton, Funded Programs Consultant
Illinois Braille and Sight Savings School
(Jack Hartong, Supt.), Jacksonville
Illinois Children's Hospital-School
(Paul Kavanaugh, Supt.), 1950 W. Roosevelt Rd., Chicago
Illinois School for the Deaf
(Kenneth Mangan, Supt.), Jacksonville
Illinois Soldiers' and Sailors' Children's School
(Andrew Spelios, Supt.), Normal
Illinois Veterans' Home
(Melvin Koch, Supt.), Quincy
Illinois Visually Handicapped Institute
(Thomas Murphy, Supt.), 1151 S. Wood St., Chicago
Community Services for the Visually Handicapped
(Peter R. Paul, Supt.), Room 1700, 160 N. LaSalle St., Chicago
Evelyn Edwards Emergency Child Care Center
(John P. Halsey, Acting Administrator), 2020 W. Roosevelt Rd., Chicago
Herrick House Children's Center
(Thomas P. Brennan, Administrator), West Bartlett Rd., Bartlett
Southern Illinois Children's Service Center
(William F. Ayers, Administrator), Hurst
Maryville Children's Center
(James W. DeLeonardis, Administrator), Maryville

Program Operations

Rockford office, 4302 N. Main St.
Rock Falls office, 203½ First Ave.

Aurora office, 361 Old Indian Trail
Waukegan office, 215 Water St.
Lake-West office, 309 N. Lake Ave., Mundelein
McHenry office, 224 W. Judd St., Woodstock
Joliet office, 257 Springfield Ave.
Kankakee office, Suite 110, 139 N. Dearborn Ave.
Chicago Central office, 1026 S. Damen Ave.
Chicago East office, 1439 S. Michigan Ave.
Chicago North office, 4320 W. Montrose Ave.
Chicago South office, 9718 S. Halsted St.
Chicago West office, 1026 S. Damen Ave.
Chicago Special Services office, 1439 S. Michigan Ave.
Peoria office, 5415 N. University Ave.
Moline office, 1805 Seventh St.
Ottawa office, 412 W. Madison St.
Galesburg office, 121 S. Prairie
Champaign office, 2125 S. First St.
Bloomington office, 301 Prospect Rd.
Danville office, 110 E. Williams
Decatur office, 125 N. Franklin St.
Mattoon office, 1000 Broadway
Paris office, 327 N. Main St.
Springfield office, 4500 S. Sixth St. Rd.
Quincy office, 410 N. Ninth St.
Jacksonville office, 502 Westgate Ave.
Carlinville office, 494½ West Side Square
East St. Louis office, 917 Martin Luther King Dr.
Edwardsville office, 116 Hillsboro Ave.
Sparta office, 121½ W. Broadway
Marion office, 2209 W. Main St.
Olney office, 1108 S. West St.
Salem office, 205 E. Locust St.
Murphysboro office, 21 N. 11th St.
Harrisburg office, 219 S. Main St.
Metropolis office, City National Bank Bldg., Fifth and Ferry Sts.
Cairo office, 529 Cross St.

Office of Child and Family Advocacy

1026 S. Damen Ave., Chicago
Bobby R. Offutt, *Director*
Sharon Garber, Ombudsman, Springfield
Reginald Patrick, Ombudsman, Chicago

Financial Management

524 South Second St., Springfield
Matthew J. Finnell, Chief

Information Systems

524 South Second St., Springfield
August G. Egger, Jr., Chief

Central and Field Business Management

524 South Second St., Springfield
Carlos Gwin, Chief

Personnel Administration

524 South Second St., Springfield
Alex J. Jones, Chief Personnel Officer

DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
LeRoy P. Levitt, M.D., *Director*

Office of the Director

Robert Y. Anderson, Special Assistant
Jerome F. Goldberg, Chief Legal Counsel
Meyer Proctor, Chief, Public Information Office

Office of the Auditor

George M. Skadden, Chief Auditor

Deputy Director For Management Services

Alfred G. Ronan, Deputy Director

Division of Finance and Evaluation Services

Carlton H. Jencks, Manager

Division of Information Services

Leonard D. Schaeffer, Manager

Division of Legal Services

Jerome F. Goldberg, Manager

Department of Personnel, Mental Health Field Services

John Meyer, Chief Personnel Officer

Clinical Services and Programs

Patrick Staunton, M.D., *Deputy Director*

James F. Griffin, Jr., *Alcoholism Program Advisor*

Gerald Kissin, Ph.D., *Children and Adolescent Program Advisor*

Peter Levinson, Ph.D., *Research Program Advisor*

Matthew D. Parrish, M.D., *Training Program Advisor*

Joseph Saxl, *Accreditation Program Advisor*

Richard Blanton, Ph.D., *(Acting) Group Administrator, Division of Mental Retardation*

A. L. Bowen Children's Center, A. J. Shafter, Ph.D.,
Superintendent, Harrisburg, 62946

Dixon State School, David Edelson, Superintendent,
Dixon, 61021

William W. Fox Children's Center, Richard G. Ken-
ney, Ed.D., Superintendent, Dwight, 60420

Lincoln State School, Lawrence Bussard, Superinten-
dent, Lincoln, 62656

Elisabeth Ludeman Mental Retardation Center, Fred
McCormack, Superintendent, Park Forest 60466

Warren G. Murray Children's Center, Walter Plass-
man, M.D., Superintendent, Centralia

Lester H. Rudy, M.D., *Group Administrator, Illinois
Mental Health Institutes*

Illinois State Pediatric Institute, Herbert J. Grossman,
M.D., Director, 1640 West Roosevelt Road, Chicago
60608

Illinois State Psychiatric Institute, Lester H. Rudy,
M.D., Director, 1601 West Taylor Street, Chicago 60612

Institute for Juvenile Research, Frank T. Rafferty,
M.D., Director, 907 Wolcott Street, Chicago 60612

Edward C. Senay, M.D., *Administrator, Illinois Drug
Abuse Program*

Regions and Institutions

1A (ROCKFORD): Donald W. Hart, Administrator, H.

Douglas Singer Zone Center, 4402 N. Main St.,
Rockford 61103

H. DOUGLAS SINGER ZONE CENTER: William G.
Smith, M.D., Superintendent, Rockford 61103

1B (PEORIA): James Ward, M.D., Administrator,
George A. Zeller Zone Center, 5407 N. University,
Peoria 61614

GEORGE A. ZELLER ZONE CENTER, James Ward,
M.D., Superintendent, Peoria 61614

EAST MOLINE STATE HOSPITAL: Konstantin Di-
mitri, M.D., Superintendent, East Moline 61244

GALESBURG STATE RESEARCH HOSPITAL: An-
gelo Zocchi, M.D., Acting Superintendent, Galesburg
61401

PEORIA STATE HOSPITAL: Henry D. Staras, M.D.,
Superintendent, Peoria 61607

2 (CHICAGO): Patrick R. Staunton, M.D., Acting Admin-
istrator, 232 E. Ohio St., Chicago 60611

CHICAGO-READ MENTAL HEALTH CENTER:
John Nelson, M.D., Superintendent, 6500 W. Irving
Park Rd., Chicago 60634

JOHN J. MADDEN MENTAL HEALTH CENTER:
Robert deVito, M.D., Superintendent, 1200 S. First
Ave., Hines 60141

ELGIN STATE HOSPITAL: Robert J. Mackie, M.D.,
Superintendent, Elgin 60120

KANKAKEE STATE HOSPITAL: Gabriel Misevic,
M.D., Superintendent, Kankakee 60901

MANTENO STATE HOSPITAL: John R. Collier, Su-
perintendent, Manteno 60950

TINLEY PARK MENTAL HEALTH CENTER: H.
C. Piepenbrink, Superintendent, Tinley Park 60477

3A (SPRINGFIELD): William H. Anderson, M.D., Admin-
istrator, Andrew McFarland Zone Center, 901 South-
wind Road, Springfield 62703

ANDREW MCFARLAND ZONE CENTER: Martin
Cohen, Ph.D., Superintendent, Springfield 62703

JACKSONVILLE STATE HOSPITAL: Andrew L.
Hoekstra, M.D., Superintendent, Jacksonville 62650

3B (DECATUR-CHAMPAIGN): Walter Kemper, M.D.,
Administrator, Adolf Meyer Zone Center, 2310 East
Mound Road, Decatur 62526

ADOLF MEYER ZONE CENTER, Norris Hansell, M.D.,
Superintendent, 2310 East Mound Road, Decatur
62526

HERMAN M. ADLER ZONE CENTER (Children); J.
Gregory Langan, Ed.D., Superintendent, 2204 Grif-
fith Dr., Champaign 61820

4 (EAST ST. LOUIS): Ivan Pavkovic, M.D., Administra-
tor, Alton State Hospital, 4500 College Ave., Alton
62002

ALTON STATE HOSPITAL: Endré Komlos, M.D.,
Medical Director; Jos. Gruber, Admin. Director,
Alton 62002

ILLINOIS SECURITY HOSPITAL, Terry B. Brelje,
Ph.D., Superintendent, Chester 62233

5 (CARBONDALE): Robert C. Steck, M.D., Administrator,

Anna State Hospital, Anna 62906
 ILLINOIS MENTAL HEALTH INSTITUTES: Lester
 H. Rudy, M.D., Administrator, 1601 W. Taylor St.,
 Chicago 60612
 INSTITUTE FOR JUVENILE RESEARCH: Frank T.
 Rafferty, M.D., Director, 907 S. Wolcott St., Chicago
 60612

ILLINOIS STATE PEDIATRIC INSTITUTE: Herbert
 J. Grossman, M.D., Director, 1601 W. Taylor St.,
 Chicago 60612

ILLINOIS STATE PSYCHIATRIC INSTITUTE: Les-
 ter H. Rudy, M.D., Director, 1601 W. Taylor St.,
 Chicago 60612

STATUTORY BOARDS AND COUNCILS

1. Mental Health Commission

Honorable Esther Saperstein, Chicago, *Chairman*
 Honorable Charles J. Fleck, Jr., Chicago, *Vice-Chairman*
 Honorable Frank M. Ozinga, Evergreen Park, Executive
 Secretary
 Honorable Daniel P. O'Brien, Jr., Chicago
 Honorable E. J. "Zeke" Giorgi, Rockford
 Honorable Michael F. Zlatnik, Chicago
 John L. Cutter, M.D., Evergreen Park
 Mrs. Elizabeth Ferry, Decatur
 Edward J. Copeland, Chicago
 Ex Officio—Albert J. Glass, M.D., Director,
 Department of Mental Health

2. Mental Health Planning Board

Mrs. Alice B. Ihrig, Oak Lawn, *Chairman*
 Donald J. Caseley, M.D., Chicago
 Donald Moss, Chicago
 Ray Moss, Clinton
 John Parkhurst, Peoria
 John R. Schuerman, Ph.D., Chicago
 Brockman Schumacher, Ph.D., Carbondale
 Honorable Robert S. Juckett, Sr., Park Ridge
 Honorable Howard R. Mohr, Forest Park
 Honorable Esther Saperstein, Chicago
 Honorable Anthony Scariano, Chicago Heights

Ex Officio:

William H. Ireland (Chairman, Council of State and
 Federal Agencies), Springfield
 Judith S. Schild, CSW, ACSW (Chairman, Council of
 Professional Societies), Chicago
 Jerome Winer, M.D. (Chairman, Council of Univer-
 sities), Chicago
 LeRoy Levitt, M.D., (Director, Department of Mental
 Health) Chicago
 Mrs. Hazel Blumenthal, Executive Secretary

3. Board of Reimbursement Appeals

(vacant)
 Harold Meitus, Chicago
 Richard L. Thies, Urbana

4. Psychiatric Advisory Council

Roy R. Grinker, Sr., M.D., Chicago, *Chairman*
 H. H. Garner, M.D., Chicago *Vice-Chairman*
 George Pollock, M.D., Chicago
 Melvin Sabshin, M.D., Chicago
 Lester H. Rudy, M.D., Chicago
 Jackson Smith, M.D., Hines

Harold M. Visotsky, M.D., Chicago

Ex Officio—LeRoy Levitt, M.D., Director, Department of
 Mental Health

5. Advisory Council —PL 88-164—Construction Grants

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 Henry S. Monroe, Winnetka
 George K. Hendrix, Springfield
 David M. Kinzer, Chicago
 Hiram Sibley, Chicago
 Mrs. Bernice T. Van der Vries, Evanston
 Robert A. Henderson, Ed.D., Urbana
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Advisory Committee on Pediatric Lead Poisoning

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W. Robert Elghammer, M.D., Danville
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Dr. Wm. Hamilton, Carbondale
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Assistant Professor of Surgery
Abraham Lincoln School of Medicine
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Subcommittee on Epidemiology

DEPARTMENT OF REGISTRATION AND EDUCATION

109 Capital Building, Springfield
Dean Barringer, Ph.D., *Director*
Peter A. Kotsos, *Assistant Director*
John Galvin, *Coordinator*
John B. Hayes, *Supt. of Registration*

The department is primarily concerned with the registration, licensing and enforcement of 32 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

Kenneth H. Schnepp, M.D., Springfield, *Chairman*
Paul Tullio, D.C., Chicago
William G. McCarthy, M.D., Dolton
Dale E. Richardson, D.O., Pontiac
S. David Ross, M.D., Springfield
Nat E. Smith, M.D., Chicago
Warren D. Tuttle, M.D., Harrisburg

Medical Practice Act

LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

- (a) the expiration of 6 months after the filing of such written application, or
- (b) the decision of the Department that the

applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

Minimum standards of professional education. Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a

medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except

that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Aug. 2, 1965.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$10.

REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The Department may revoke, or suspend, place on probationary status, or take any other discipli-

nary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

- "1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, if the Department determines, that after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved July 23, 1971).
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group

of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;

10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state;
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."
14. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of a decree by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Committee of Physicians that he has been determined to be recovered from mental illness by the court and upon the Committee's recommendation that he be permitted to resume his practice. (added by Act approved July 26, 1971).

15. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in

partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divided a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each. (added by Act approved July 31, 1971).

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE I—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING Sys-

TEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy

(a) Embryology; (b) Histology; (c) Neuroanatomy

(2) Physiology and Chemistry

(3) Pathology and Bacteriology

(4) Diagnosis

(a) Physical; (b) Differential; (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required

by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department, be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified

by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

RULE IV—APPLICATION FOR EXAMINATION

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1-b, or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his intern-

ship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European medical colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating internships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

THEORETICAL

Chemistry, Physiology, Anatomy, Pharmacology, Pathology, Bacteriology, Medicine, Public Health & Preventive Medicine, Obstetrics & Gynecology, Surgery, Pediatrics, Psychiatry

CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

THEORETICAL

Chemistry & Physiology, Anatomy & Histology, Pathology & Bacteriology, Diagnosis, Hygiene & Medical Jurisprudence, Eye, Ear, Nose, & Throat, Dermatology, Pediatrics & Neurology, System of Practice, Obstetrics (for graduates of approved

osteopathic colleges)

PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60% in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75% or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75% has been received in that part of the examination.

5. Applicants who take the regular written examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

RULE VII—LICENSURE

1. An examinee who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

RULE VIII—TEMPORARY CERTIFICATES OF REGISTRATION

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such cur-

rent Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

4. State hospital permits of physicians not otherwise licensed to practice may be renewed only twice after July 1, 1973, for one year periods each, with all original permits and renewals to expire on July 1 after issuance. After July 1, 1974, all permit holders seeking renewal will be required to pass new examination given by Department of Registration and Education, or an equivalent examination.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in

October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not** a substitute for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act*. [Chp. 91, Sec. 16i, Paragraph 24, 1967 Rev. Stat.])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Dental Examining Committee

Ralph H. Council, Champaign, *Chairman*
 Ralph H. Baahlmann, D.D.S., Alton
 Hugh D. Burke, D.D.S., Dixon

Herbert Gustavson, D.D.S., Northbrook
 Sidney Neuwirth, D.D.S., Peoria
 William T. Osmanski, D.D.S., Wilmette
 William L. Podesta, D.D.S., Mattoon

Illinois Committee on Nursing Examiners

Miss Patricia A. Wagner, Chicago, *Chairman*
 Miss Charlotte F. Anders, Chicago
 Mrs. Frances Barge, Chicago
 Mrs. Ina Ingwersen, Collinsville
 Mrs. Mary O'Meara, DeKalb
 Mrs. Harriet Olson, Moline
 Dr. Kathleen Smyth, Forest Park

Illinois Optometric Examining Committee

Jose E. Aponte, O.D., Park Ridge, *Chairman*
 Henry R. Moore, Chicago
 Gene Ossello, O.D., Dolton
 Robert W. Stoelzle, Carbondale
 Floyd Woods, O.D., Oak Lawn

Pharmacy Examining Committee

Dr. Daniel Nona, Chicago, *Chairman*
 John Barlow, Sullivan
 Louis Gdalmann, Chicago
 Richard Hilden, Downers Grove
 Fred L. Janes, Avon
 Philip Sacks, Norridge
 Irwin S. Thornton, Chicago

Physical Therapy Examining Committee

Vilma Evans, R.P.T., *Chairman*
 Robert Babbs, Chicago
 James Mason Gray, Springfield
 John J. Mustari, Oak Lawn
 Arthur A. Rodriguez, Palos Park

Podiatry Examining Committee

Charles H. Delano, D.P.M., *Chairman*
 Joseph M. Giannini, Chicago

Psychologist Examining Committee

Frank Kobler, Chicago, *Chairman*
 Morris Aderman, Skokie
 Frank Cospin, Champaign
 Dorothy Jean Dettmar, Hinsdale

DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street
 Springfield, IL. 62706
 Alfred Slicer, *Director*

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical edu-

cation pursuant to the Federal Vocational Education Act, as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Statutory Members:

Chairman of the Board:

Jerome G. Miller, D.S.W., Director
Department of Children & Family Services
Suite 1713, 160 N. LaSalle St., Chicago 60601
Robert J. Williams, Director
Department of Agriculture
Junior Livestock Bldg., State Fairgrounds
Springfield 62706
Kenneth W. Holland, Director
Department of Labor
704 State Office Building, Springfield 62706
LeRoy P. Levitt, M.D., Director
Department of Mental Health
Rm. 1500, 160 N. LaSalle St., Chicago 60601
Michael J. Bakalis, Ph.D.
Superintendent of Public Instruction
302 State Office Building, Springfield 62706
Joyce C. Lashof, M.D., Director

Department of Public Health
535 W. Jefferson Street, Springfield 62706
Dean Barringer, Ph.D., Director
Department of Registration & Education
628 E. Adams Street, Springfield 62706

Lay Members:

Dorothy Grant Arndt
1330 26th Avenue, Rock Island 61201
Frank C. Bacon, Jr.
Sears Bldg., 430 South State Street, Chicago 60605
Harold Byers
2218 Park Hill Drive, Highland 62249
Mary E. McKean
447 Arlington, Elmhurst 60126
Emmett Palmer
6 N. 431 Gary Avenue, Keeneyville
Tony Vasquez
2645 South Christiana, Chicago 60623

ILLINOIS REGIONAL MEDICAL PROGRAM REGIONAL ADVISORY GROUP

The Illinois Regional Medical Program, which began in 1967, is a federally funded but autonomous organization charged with improving the health care of the citizens of the state of Illinois. The program objectives are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. IRMP supports and engages in activities aimed at: 1) improving the health care delivery system 2) increasing the availability and capability of health care personnel and 3) controlling major diseases. The Regional Advisory Group, the policy-making body of the IRMP, must approve all project applications for funding. The RAG is composed of representatives from the medical profession, allied health professions, hospital administration, planning agencies, voluntary and official health groups, medical schools and teaching hospitals in the state, as well as members of the general public familiar with the financing of, and the need for, health care.

Regional Advisory Group

Dexter Nelson, M.D., Princeton, *Chairman*
Donald P. Colleton, Chicago, *Vice-Chairman*
Leonidas H. Berry, M.D., Chicago
Daniel K. Bloomfield, M.D., Urbana
Josephine A. Brandt, R.N., Moline
Andrew Brislen, M.D., Chicago
Donald J. Caseley, M.D., Chicago
Jacob Cates, Belvidere
Louis deBoer, Chicago
Vilma Evans, R.P.T., Danville
Cecelia Fennessy, R.N., Chicago
Merle H. Glick, Peoria
Stanley Goldstein, M.D., Decatur
John Grede, Ph.D., Chicago

Arthur L. Grist, Edwardsville
William J. Grove, M.D., Chicago
Emanuel Hallowitz, Chicago
George K. Hendrix, Springfield
Leon O. Jacobson, M.D., Chicago
Irwin Jarett, Ph.D., Springfield
Allen Kelly, Eldorado
Richard H. Kessler, M.D., Chicago
Robert A. Kistner, D.O., M.D., Chicago
Marion Lamet, Warsaw
August P. Lemberger, Ph.D., Chicago
Mark H. Lepper, M.D., Chicago
LeRoy P. Levitt, M.D., Chicago
Henry J. Luckhardt, O.D., Westmount
Charles Marshall, Chicago
W. Henderson May, Springfield
Harold W. Maysent, Rockford
E. Duke McNeil, Chicago
Robert J. Parker, M.D., Bloomington
Caesar Portes, M.D., Chicago
Morris Profit, M.D., Chicago
Will Rasmussen, Chicago
Edward F. Scanlon, M.D., Evanston
Berry Seng, M.D., Morris
Maynard Shapiro, M.D., Chicago
Reverend Reuben A. Sheares, II, Chicago
Hiram Sibley, Chicago
Kenneth E. Steffan, Chicago
John C. Troxel, M.D., Chicago
Calvin Chandler, Chicago
Sheldon Wallach, D.D.S., Glenwood
The Honorable James Walton, Chicago
J. A. Wells, M.D., Maywood
Franklin D. Yoder, M.D., M.P.H., Springfield

LICENSED CLINICAL LABORATORIES

The following is a list of licensed clinical laboratories certified by the Illinois Department of Public Health in states other than Illinois; for a list of Illinois laboratories write IDPH, 503 State Office Building Springfield, IL 62706.

CALIFORNIA

BERKELEY

Solano Laboratories, Inc.
2920 Telegraph Ave., 94705

SAN DIEGO

Pap Smear Center, Inc.
4232 University Ave., 92105

VAN NUYS

Bio-Science Labs
7600 Tyrone Ave., 91405

WOODLAND HILLS

Lab Procedures—Div. of Upjohn Co.
6330 Variel Drive, 91364

FLORIDA

OAKLAND PARK

Broward Brock Labs, Div. of Damon
3290 N.E. 12th Ave., 33308

INDIANA

HAMMOND

Physicians Laboratory
5246 Hohman Ave., Rm. 409, 46320

JEFFERSONVILLE

Physicians Precision Automated Labs
3408 Industrial Parkway, 47130

IOWA

DAVENPORT

Quad Cities Pathologists Group
125 Kirkwood Blvd., 52803
Quad Cities Pathologists Group
1814 East Locust, 52803

KENTUCKY

LOUISVILLE

Clinical Diagnostic Labs, Inc.
634 South Floyd St., 40202

KANSAS

WICHITA

Associated Labs, Inc.
511 E. 21st St., 67208
3333 E. Central, 62701
911 N. Hillside, 62701

MICHIGAN

GRAND RAPIDS

Continental Bio-Cln
2823 Clydon SW

MINNESOTA

ROCHESTER

Mayo Medical Service Ltd.
200 First St. SW, 55901

MISSOURI

CLAYTON

Cooper Medical Laboratory
141 N. Meramc, 63105

ST. LOUIS

Allen Medical Labs, Ltd.
2821 N. Ballas Rd., 63131
Clinical Labs of St. Louis, Inc.
11636 Administration Dr., 63141
Miller Laboratories, Inc.

10845 Baur Blvd., 63132

Midwest Medical Laboratory, Inc.

4141 Forest Park Blvd., 63108

Pathology Services, Inc.

10845 Baur Blvd., 63132

NEW JERSEY

HACKENSACK

Metpath, Inc.
60 Commerce Way, 07606

METUCKEN

Center for Lab Medicine
16 Pearl St., 08840

NEWARK

GIB Labs, Inc.
213 Washington St., 07101

NUTLEY

Roche Clinical Labs, Inc.
340 Kinsland Ave., 07110

TEANECK

Metpath, Inc.
185 W. Englewood Ave., 07666

WEST CALDWELL

Roche Clinical Labs, Inc.
One Fairfield Crescent, 07006

NEW YORK

GREAT NECK

New York Med. Labs
150 Community Dr., 11020

OHIO

COLUMBUS

Automated Medical Service of Ohio, Inc.
1466 S. High St., 43207

MANSFIELD

Automated Medical Services of Ohio, Inc.
666 Park Ave., West, 44906

POWELL

Searle Diagnostic, Inc.
2775 Home Rd., 43065

OREGON

PORTLAND

United Medical Labs, Inc.
Sandy Annex, 10700
N.E. Sandy Blvd., 97220
Toxicology Lab, 10005
N.E. Sandy Blvd., 97220
Exfoliative Cytology Lab
10035 N.E. Sandy Blvd., 97220
Lipid Lab
10504 N.E. Sandy Blvd., 97220
6060 N.E. 112th, 97208

TENNESSEE

MEMPHIS

Memphis Pathology Lab
250 S. Bellevue, 38104

WISCONSIN

MILWAUKEE

Bio-Medical Labs
811 E. Wisconsin Ave., 53202
Drug L.D. Laboratory, Inc.
4608 W. Burleigh St., 53210

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

Michael Reese Hospital and Medical Center
 29th Street and Ellis Ave., Chicago 60616
 Fredric L. Coe, M.D.

Presbyterian-St. Luke's Hospital
 1753 West Congress Parkway, Chicago 60612
 Todd S. Ing, M.D.

Washington University Renal Unit

Chromalloy American Kidney Center
 (Barnes Hospital)
 4949 Barnes Hospital Plaza, St. Louis, Mo. 63110
 Eduardo Slatopolsky, M.D.

The Jewish Hospital of St. Louis
 216 S. Kingshighway, St. Louis, Mo. 63110
 Herbert Lubowitz, M.D.

Memorial Hospital
 First and Miller Sts., Springfield 62701
 Richard Bilinsky, M.D.

Evanston Hospital
 2650 Ridge Ave., Evanston 606201
 Bernard Adelson, M.D.

University Hospitals
 Department of Medicine
 1300 University Ave., Madison, Wis. 53706
 Arvin B. Weinstein, M.D.

University of Illinois Research and Educational
 Hospitals
 840 South Wood St., Chicago 60612

Franklin Schwartz, M.D.

Mayo Clinic
 Internal Medicine & Nephrology, Rochester, Minn. 55901
 William J. Johnson, M.D.

University of Chicago Hospitals & Clinics
 (Includes LaRabida Sanitarium)
 950 East 59th St., Chicago
 Edmund Lewis, M.D.

Mount Sinai Hospital Medical Center
 Fifteenth and California Aves., Chicago, 60608
 Earl C. Smith, M.D.

Northwestern Memorial Hospital
 Superior and Fairbanks Ct., Chicago 60611
 Francesco del Greco, M.D.

West Suburban Hospital and West Suburban Kidney
 Center, Inc.
 518 North Austin Blvd., Oak Park 60302
 Robert C. Muehrcke, M.D.

Rockford Memorial Hospital
 2300 North Rockton Ave., Rockford 61101
 Ewald T. Sorensen, M.D.

Cook County Hospital
 1825 West Harrison St., Chicago 60612
 George Dunea, M.D.

St. Francis Hospital
 523 N. E. Glen Oak, Peoria 61603
 Robert Pflederer, M.D.

APPROVED RENAL DIALYSIS UNITS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

The Children's Memorial Hospital
 2300 Children's Plaza, Chicago 60614
 Peter R. Lewy, M.D.

Lake View Memorial Hospital
 812 North Logan Ave., Danville 61832
 Joseph G. Ellis, M.D.

Mercy Hospital
 1400 West Park Ave., Urbana 61801
 R. E. Tirona, M.D.

St. Joseph Hospital
 2900 North Lake Shore Dr., Chicago 60657
 Gordon Lang, M.D.

Galesburg Cottage Hospital
 674 North Seminary St., Galesburg 61401
 Agha Babanoury, M.D.

Roosevelt Memorial Hospital
 426 West Wisconsin St., Chicago 60614
 Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital
 15510 Page Ave., Harvey 60426
 Alexander B. White, M.D.

Doctors Memorial Hospital
 404 West Main St., Carbondale 62901
 John Taylor, M.D.

Blessing Hospital
 1005 Broadway, Quincy 62301
 Hugh Espey, M.D.

Jefferson County Memorial Hospital
 909 Shawnee St., Mount Vernon 62864
 John M. Dunn, M.D.

Victory Memorial Hospital
 1324 North Sheridan Rd., Waukegan 60085
 John Freeland, M.D.

Central DuPage Hospital
 0 North 025 Winfield Rd., Winfield 60190
 Paul Balter, M.D.

Loyola University (Foster G. McGaw) Hospital
 2160 South First Ave., Maywood 60153
 A. R. Lavender, M.D.

St. Margaret Hospital
 25 Douglas St., Hammond, Ind.
 James H. Greenwald, M.D.

Edgewater Hospital
 5700 N. Ashland, Chicago 60660
 Gabriel Schwartz, M.D.

St. Elizabeth's Hospital
 211 S. Third St., Belleville 62221
 Joseph Santiago, M.D.

Silver Cross Hospital
600 Walnut St., Joliet 60432
Robert S. Markelz, M.D.

For further information contact:

Mrs. Ruth S. Shriner, ACSW—Coordinator Renal Disease
Program, Illinois Department of Public Health
4398 South Jeffery St., Springfield 62761
Phone: (217) 786-6980

Dialysis for Veterans with kidney disease is available at
Veterans Administration Hospital, Hines 60141
A. R. Lavender, M.D.

Veterans Administration Research Hospital, Chicago
Peter Ivonovich, M.D.

Satelites

West Suburban Kidney Center
St. Peter's Evangelical Lutheran Church
500 Hannah, Forest Park

Lombard Satellite Unit
First Church of Lombard, Lombard
University of Illinois Hospitals
Near North Medical Clinic Satellite Unit
1200 North LaSalle St., Chicago 60610
Memorial Hospital—Springfield
St. Mary Hospital
1415 Vermont St., Quincy
Renal Facility
913 N. Rutledge, Springfield
Alton Memorial Hospital
Alton
Doctors' Park
701 North Walnut St., Springfield
Douglas Nursing Home
Matton Memorial Hospital, Mattoon
Evanston Hospital Dialysis Center
Niles-Day-Springman Satellite
Lawrencewood Shopping Center
Waukegan Road, Niles

ARTIFICIAL KIDNEYS FOR ACUTE POISONING CASES

Alton Memorial Hospital Memorial Drive Alton	Phone: 462-8551 Person in Charge: Mr. Paul Raczkiewicz Miss Sharon Spooner, R.N. Location in Hosp: Renal Unit
Copley Memorial Hospital Lincoln & Weston Avenues Aurora	Phone: 897-6021 Person in Charge: M. J. Carbon, M.D. Location in Hosp: Intermediate Care
St. Elizabeth's Hospital 211 S. 3rd Street Belleville	Phone: 234-2120 Person in Charge: Joseph Santiago, M.D. Sister Jamesine Lamb, R.N. Location in Hosp: Hemodialysis Unit
Doctors Memorial Hospital 404 West Main Carbondale	Phone: 549-0721 Person in Charge: Sam Namminga, M.D. Location in Hosp: Renal Dialysis
Children's Memorial Hospital 2300 Children's Plaza Chicago	Phone: 649-4000 Person in Charge: Peter Lewy, M.D. Location in Hosp: Nephrology
Cook County Hospital 1825 West Harrison Chicago	Phone: 633-6000 Person in Charge: George Dunea, M.D. Location in Hosp: Renal
Edgewater Hospital 5700 N. Ashland Avenue Chicago	Phone: 878-6000 Person in Charge: Gabriel Schwartz, M.D. Location in Hosp: Surgery
La Rabida Children's Hospital & Research Center E. 65th St. at Lake Michigan Chicago	Phone: 363-6700 Person in Charge: Dr. Ronald J. Kallen Location in Hosp: Hemodialysis Unit, 2nd Floor
Mercy Hospital & Medical Center Stevenson Expressway at King Drive Chicago	Phone: 842-4700 Person in Charge: Carlos Otero, M.D. Location in Hosp: Medicine Dept.
Michael Reese Hosp. & Medical Center 2900 S. Ellis Chicago	Phone: 791-3400 or 791-3395 Person in Charge: Mr. Willis Hill Location in Hosp: Dialysis Section Dept.
Mt. Sinai Hospital Medical Center of Chicago 15th & California Avenue Chicago	Phone: 542-2505 Person in Charge: Earl Smith, M.D. Location in Hosp: Medicine Dept.

Northwest Hospital Inc. 5645 W. Addison St. Chicago	Phone: 282-7000 Person in Charge: Jayme Neuman, M.D. Location in Hosp: Intensive Care
Northwestern Memorial Hospital Superior & Fairbanks Court Chicago	Phone: 649-2000 Person in Charge: Francesco delGreco, M.D. Location in Hosp: Dialysis Dept.
Rush-Presbyterian-St. Luke's 1753 West Congress Parkway Chicago	Phone: 942-5000 Person in Charge: Todd Ing, M.D. Location in Hosp: Renal Dialysis
Ravenswood Hospital Medical Center 4550 N. Winchester Chicago	Phone: 878-4300 Person in Charge: Norbert Nadler, M.D. Location in Hosp: Nursing Unit, 5-West
Roosevelt Memorial Hospital 426 W. Wisconsin Chicago	Phone: 664-8000 Person in Charge: Franklin Schwartz, M.D. Location in Hosp: Intensive Care, 3rd Floor
St. Joseph Hospital 2900 N. Lake Shore Drive Chicago	Phone: 528-1000 Person in Charge: Franklin Schwartz, M.D. Location in Hosp: Nephrology & Renal Dialysis
University of Chicago Hospital & Clinics 950 E. 59th Chicago	Phone: 947-5797 Person in Charge: Adrian Katz, M.D. Location in Hosp: Kidney Dialysis Lab.
University of Illinois Hospital 840 S. Wood St. Chicago	Phone: 996-7000 Person in Charge: Luis F. Gutierrez, M.D. Location in Hosp: Medicine/Nephrology or Kidney Unit 443-5318
Lake View Memorial Hospital 812 N. Logan Avenue Danville	Phone: 443-5000 Person in Charge: J. G. Ellis, M.D. or Sharon Tuggle, R.N. Location in Hosp: Intensive Care & Hemodialysis Unit
Decatur Memorial Hospital 2333 North Edward Decatur	Phone: 877-9351 Person in Charge: Richard T. Bilinsky, M.D. Location in Hosp: Renal Unit
St. Joseph Hospital 77 Airlite Elgin	Phone: 741-5400 Person in Charge: Mr. Jerry Pearson Location in Hosp: Emergency Dept.
Sherman Hospital 934 Center Street Elgin	Phone: 742-9800 Person in Charge: A. Hassan Khazei, M.D. Location in Hosp: Surgery
Memorial Hospital of DuPage Co. 209 Avon Road Elmhurst	Phone: 833-1400 Person in Charge: J. J. Simonaitis, M.D. Location in Hosp: Dept. of Medicine
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: 492-6815 Person in Charge: Dorothy Welch, R.N. Location in Hosp: Hemodialysis
St. Francis Hospital of Evanston 355 Ridge Avenue Evanston	Phone: 492-4000 Person in Charge: Dongsuk Kim, M.D. Location in Hosp: Nursing
Galesburg Cottage Hospital 674 North Seminary Street Galesburg	Phone: 343-4121, ext. 230 Person in Charge: Carol Weber, R.N. Location in Hosp: Hemodialysis Unit
Ingalls Memorial Hospital 15510 Page Avenue Harvey	Phone: 333-2300 Person in Charge: Norman R. Brill, M.D. Location in Hosp: Renal Dialysis

Silver Cross Hospital 1200 Maple Road Joliet	Phone: 729-7111 Person in Charge: Location in Hosp:	R. A. Markelz, M.D. Special Care Floor Building #2, Floor #2
Mattoon Memorial Hospital 2101 Champaign Mattoon	Phone: 234-8881 Person in Charge: Location in Hosp:	Richard T. Bilinsky, M.D. Hemodialysis
Foster G. McGaw Hosp. of Loyola University 2160 South 1st Avenue Maywood	Phone: 531-3000 Person in Charge: Location in Hosp:	Edwina Franand Renal Dialysis
Jefferson Memorial Hospital 909 Shawnee Mt. Vernon	Phone: 242-3400 Person in Charge: Location in Hosp:	Cheryl Books, R.N. John M. Dunn, M.D. Kidney Dialysis Unit
West Suburban Hospital 518 N. Austin Blvd. Oak Park	Phone: 383-6200 Person in Charge: Location in Hosp:	ext. 6587 Robert Muehrcke, M.D. Kidney Dialysis Center
Christ Community Hospital 4440 West 95th St. Oak Lawn	Phone: 425-8000 Person in Charge: Location in Hosp:	Joseph Oyama, M.D. Physical Therapy & Rehab.
Methodist Hospital of Central Illinois 221 N.E. Glen Oak Ave. Peoria, Illinois 61603	Phone: 685-6511 Person in Charge: Location in Hosp:	Miss M. Fritz, R.N. J. Meyers, M.D. Intensive Care Unit
St. Francis Hospital 530 N.E. Glen Oak Peoria	Phone: 672-2000 Person in Charge: Location in Hosp:	R. A. Pflederer, M.D. Hemodialysis
Blessing Hospital 1005 Broadway Quincy	Phone: 223-5811 Person in Charge: Location in Hosp:	Mrs. Marian Almasy, R.N. Hugh Espey, M.D. Renal Dialysis
St. Mary's Hospital 1415 Vermont Quincy	Phone: 223-1200, Person in Charge: Location in Hosp:	ext. 265 Rosemary Venus, R.N. Renal Unit
Rockford Memorial Hospital 2400 N. Rockton Ave. Rockford	Phone: 968-6861 Person in Charge: Location in Hosp:	E. T. Sorensen, M.D. Dept. of Medicine
Memorial Hospital 1st & Miller Springfield	Phone: 528-2041 Person in Charge: Location in Hosp:	Dr. Richard Bilinsky 7th Floor
Mercy Hospital 1400 West Park Urbana	Phone: 337-2233 Person in Charge: Location in Hosp:	R. F. Tirona, M.D. Mr. Michael Luth Nursing Service
Victory Memorial Hospital 1324 North Sheridan Road Waukegan	Phone: 688-3000 Person in Charge: Location in Hosp:	John P. Freeland, M.D. Dialysis Unit
Central DuPage Hospital 0 N 025 Winfield Road Winfield	Phone: 653-6900 Person in Charge: Location in Hosp:	P. Balter, M.D. Kidney Dialysis

In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:

Barnes Hospital 4949 Barnes Hospital Plaza St. Louis, Missouri	Phone: 367-6400 Person in Charge: Location in Hosp:	Dr. Edwardo Slatapolsky Renal Division
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POISON CONTROL CENTERS IN ILLINOIS

For further information contact:
Byron J. Francis, M.D., M.P.H., Chief
Division of Disease Control
Illinois Department of Public Health
535 W. Jefferson
Springfield, 62761
Phone: (217) 525-2168

ALTON

Alton Memorial Hospital
Memorial Drive
462-8851, ext. 352

AURORA

Copley Memorial Hospital
Lincoln & Weston Avenues
897-6021, ext. 725

BELLEVILLE

Memorial Hospital
4501 North Park Drive
233-7750, ext. 250

BELVIDERE

Highland Hospital
1625 S. State St.
547-5441

BERWYN

MacNeal Memorial Hospital
3249 S. Oak Park Avenue
797-3000 or 797-3159

BLOOMINGTON

Mennonite Hospital
807 North Main St.
828-5241 ext. 312
St. Joseph's Hospital
2200 E. Washington
662-3311, ext. 352

CAIRO

St. Mary's Hospital
2020 Cedar St.
734-2400, ext. 42

CANTON

Graham Hospital Association
210 W. Walnut St.
647-9058, ext. 248, ext. 230

CARBONDALE

Doctors Memorial Hospital
404 W. Main St.
549-0721

CARTHAGE

Memorial Hospital
End of South Adams St.
357-3131, ext. 84

CENTRALIA

St. Mary's Hospital
400 N. Pleasant Street
532-6731, ext. 626

CHAMPAIGN

Burnham City Hospital
407 S. 4th
337-2533

CHANUTE AIR FORCE BASE

United States Air Force Hospital
495-3133, 495-3134
Limited for treatment of military personnel
and families, except for indicated civilian
emergencies

CHESTER

Memorial Hospital
1900 State St.
826-4581, ext. 244

CHICAGO

Children's Memorial Hospital
2300 Children's Plaza
649-4161
Cook County Children's Hospital
700 S. Wood St.
633-6548
University of Illinois Hospitals
840 South Wood St.
996-6887, 996-6660
Mercy Hospital
2510 S. Prairie
842-4700, ext. 171
Michael Reese Hospital
2929 S. Ellis
791-2050
Mt. Sinai Hospital
15th & California
542-2030
Rush-Presbyterian-St. Lukes Medical Center
(Master Chicago Center for information, treatment,
and reference on poisonings)
1753 W. Congress Parkway
942-5969
Resurrection Hospital
7435 West Talcott Avenue
774-8000, ext. 401
St. Mary of Nazareth Hospital Center
1120 North Leavitt
292-5317
Wyler Children's Hospital
950 E. 59th St.
947-6231

DANVILLE

Lake View Memorial Hospital
812 N. Logan Avenue
443-5221
St. Elizabeth Hospital
600 Sager Avenue
412-6300

DECATUR

Decatur Memorial Hospital
2333 N. Edward St.
877-8121, ext. 676
St. Mary's Hospital
1800 E. Lakeshore Drive
429-2966, ext. 749

DES PLAINES

Holy Family Hospital
100 North River Road
297-1800, ext. 826

EAST ST. LOUIS

Christian Welfare Hospital
1509 Martin Luther King Dr.
874-7076, ext. 232, 216
St. Mary's Hospital
129 North 8th St.
274-1900, ext. 204, 268

EFFINGHAM

St. Anthony Memorial Hospital
503 North Maple St.
342-2121, ext. 211

ELGIN

St. Joseph's Hospital
277 Jefferson Avenue
741-5400, ext. 69
Sherman Hospital
934 Center St.
742-9800, ext. 682, 681

ELMHURST

Memorial Hospital of DuPage County
209 Avon Road
833-1400, ext. 550, 551, 552, 553

EVANSTON

St. Francis Hospital
355 Ridge Avenue
492-2440
Evanston Hospital
2650 Ridge Avenue
492-6460

EVERGREEN PARK

Little Company of Mary Hospital
2800 W. 95th St.
445-6000, ext. 221

FAIRBURY

Fairbury Hospital
519 South Fifth St.
692-2346, ext. 248

FREEPORT

Freeport Memorial Hospital
420 South Harlem Avenue
233-4131, ext. 228

GALENA

The Galena Hospital
215 Summit Street
777-1340

GALESBURG

Galeburg Cottage Hospital
695 North Kellogg
343-4121, ext. 356, 336
St. Mary's Hospital
239 South Cherry St.
343-3161, ext. 210

GRANITE CITY

St. Elizabeth Hospital
2100 Madison Avenue
876-2020, ext. 401

HARVEY

Ingalls Memorial Hospital
15510 Page Avenue
333-2300, ext. 451

HIGHLAND

St. Joseph's Hospital
1515 Main St.
654-2594

HIGHLAND PARK

Highland Park Hospital
718 Glenview Avenue
432-8000

HINSDALE

Hinsdale San & Hospital
120 North Oak St.
323-2100, ext. 336

HOOPESTON

Hoopeston Community Memorial Hospital &
Nursing Home
701 E. Orange St.
283-5531

JACKSONVILLE

Passavant Memorial Area Hospital
1600 West Walnut St.
245-9541

JOLIET

St. Joseph Hospital
333 N. Madison St.
725-7133, ext. 679, 680
Silver Cross Hospital
1200 Maple Road
729-7563

KANKAKEE

Riverside Hospital
350 N. Wall St.
933-1671, 933-2621, ext. 606
St. Mary Hospital
150 South Fifth Avenue
939-4111, ext. 735

KEWANEE

Kewanee Public Hospital
719 Elliott St.
853-3361, ext. 219

LAKE FOREST

Lake Forest Hospital
660 North Westmoreland
234-5600

LASALLE

St. Mary Hospital
1015 O'Connor Avenue
223-0607, ext. 14, 44

LINCOLN

Abraham Lincoln Memorial Hospital
315 Eighth St.
732-2161, ext. 346

MACOMB

McDonough District Hospital
525 East Grant St.
833-4101, ext. 433

MATTOON

Memorial Hospital District of Coles County
2101 Champaign Avenue
234-8881, ext. 43

MAYWOOD

McGah Memorial Hospital of Loyola University
2160 S. 1st Avenue
531-3000

McHENRY

McHenry Hospital
3516 West Waukegan Road
385-2200, ext. 614

MELROSE PARK

Westlake Community Hospital
1225 Superior St.
681-3000, ext. 226

MENDOTA

Mendota Community Hospital
Route 51 and Memorial Drive
539-7461, ext. 225

MOLINE

Moline Public Hospital
635 - 10th Avenue
762-3651, ext. 232

MONMOUTH

Community Memorial Hospital
1000 W. Harlem Avenue
734-3141, ext. 244

MOUNT CARMEL

Wabash General Hospital
1418 College Drive
262-4121, ext. 31

MOUNT VERNON

Good Samaritan Hospital
605 North Twelfth St.
242-4600

NAPERVILLE

Edward Hospital
South Washington St.
355-0450, ext. 326

NORMAL

Brokaw Hospital
Virginia at Franklin Avenue
829-7685

OAK LAWN

Christ Community Hospital
4440 West 95th St.
425-8000

OAK PARK

West Suburban Hospital
518 North Austin Blvd.
383-6200

OLNEY

Richland Memorial Hospital
800 East Locust St.
395-2131, ext. 226

OTTAWA

Community Hospital of Ottawa
701 Clinton St.
433-3100, ext. 48

PARK RIDGE

Lutheran General Hospital
1775 Dempster St.
696-2210, ext. 1460

PEKIN

Pekin Memorial Hospital
14th & Court
347-1151, ext. 241

PEORIA

Methodist Hospital
221 N.E. Glen Oak Avenue
685-4069
Proctor Community Hospital
5409 North Knoxville Avenue
691-4702, ext. 791
St. Francis Hospital
530 N.E. Glen Oak Avenue
672-2109

PERU

Peoples Hospital
925 West St.
223-3300, ext. 53, 55

PITTSFIELD

Illini Community Hospital
640 West Washington St.
285-2113, ext. 238

PRINCETON

Perry Memorial Hospital
530 Park Avenue, East
875-2811, ext. 311

QUINCY

Blessing Hospital
1005 Broadway
223-5811, ext. 255
St. Mary Hospital
1415 Vermont St.
223-1200, ext. 275

ROCKFORD

Rockford Memorial Hospital
2400 North Rockton Avenue
968-6861, ext. 441
St. Anthony Hospital
5666 E. State St.
226-2041
Swedish-American Hospital
1316 Charles St.
968-6898, ext. 602

ROCK ISLAND

Rock Island Franciscan Hospital
2701 17th Street
793-1000, ext. 2106

ST. CHARLES

Delnor Hospital
975 North Fifth Avenue
584-3300, ext. 220

SCOTT AIR FORCE BASE

USAF Medical Center
256-7363

SPRINGFIELD

Memorial Hospital
First and Miller Streets
528-2041, ext. 460
St. John's Hospital
701 E. Mason St.
544-6464, ext. 210

STREATOR

St. Mary's Hospital
111 E. Spring St.
673-2311, ext. 221, 222

URBANA

Carle Foundation Hospital
611 W. Park St.
337-3311

Mercy Hospital
1400 W. Park Avenue
337-2233, ext. 2131

WAUKEGAN

St. Therese Hospital
2615 West Washington St.
688-6470
Victory Memorial Hospital
1324 North Sheridan Road
688-4181

WINFIELD

Central DuPage Hospital
0 North, 025 Winfield Road
653-6900, ext. 556

WOODSTOCK

Memorial Hospital for McHenry County, Inc.
527 W. South St.
338-2500, ext. 232

ZION

Zion-Benton Hospital
Shiloh Boulevard
872-4561, ext. 239, 240

Medical Legal Information

(Prepared by ISMS Legal Counsel, James L. Fletcher)

The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a general counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although

the Illinois State Medical Society cannot provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be decided by the physician and the patient.

Whenever possible, the physician should discuss his fee with the patient in advance of treatment. If feasible, the understanding as to the fee should be reduced to writing as a permanent record for both parties. Not only does such a procedure minimize misunderstanding, but it may help to re-emphasize to the patient, and his carrier, the specific contractual duties that the patient has undertaken. In the absence of a specific fee agreement, a physician is entitled to "reasonable compensation" for services rendered by him.

While, as has been indicated above, a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so

long as the case requires attention. To disregard this duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw, so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured.

HOSPITAL PATIENT RECORDS

Illinois law provides that every public and private hospital in the State shall, upon the written demand of any discharged patient, permit that patient's physi-

cian or authorized attorney to examine and make copies of his hospital records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

Recently, there has been a tendency (especially in the larger cities) to expand liability and to increase the amounts of recovery once liability has been established. When a sympathetic jury views an injured patient, it may well be inclined to interpret the facts in a manner detrimental to the physician. Although the "reasonable skill" standard is not unduly harsh, it is flexible enough to make its application in a particular lawsuit quite subjective.

While the legal implications in the field of malpractice litigation are numerous in scope, basically, the physician

is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. While the cost of various types of malpractice insurance coverage is costly and still increasing, it is nonetheless recommended that extremely high limits be maintained in one's policy.

In addition to purchase of malpractice insurance, each physician should attempt to conduct his practice in such a fashion that the initiation of (and the finding of "guilty" verdicts in) malpractice litigation is greatly minimized.

The American Medical Association has published and prepared for distribution a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines

for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications; and after obtaining a signed consent from the patient and from the patient's spouse, if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the

patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In the October, 1971, issue of the *Illinois Medical Journal*, legal counsel to the Illinois State Medical Society expanded upon the recommendations of the AMA and urged that Illinois physicians also observe the following preventative safeguards:

1. Physicians should conduct their practice in hospitals so that they comply with, and live up to, the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act, and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that cases frequently are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit, and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

The Illinois State Medical Society has published a pamphlet, "The Physician's Liability in Patient Care," which is available for distribution to any physician who does not have a copy and desires one.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the recent Illinois Controlled Substances Act, physicians who dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Categories of drugs under which

registration is required are almost identical to those already established by the Federal Bureau of Narcotics and Dangerous Drugs.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

The expansion of liability has not been of unqualified benefit to patients. Fear of legal reprisal may often inhibit the free exercise of professional judgment. This fact, in many situations, can work to the disadvantage of patients.

This realization has begun to find its way into the law. The Illinois General Assembly has become convinced that liability in specific situations should be limited so that medical personnel will be free to act without hesitation.

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who render emergency medical care in good faith and for no fee, at the scene of an accident, or in the case of a nuclear attack, are not liable for injuries resulting from their care unless they engage in wilful or wanton misconduct.

Similarly, a physician who serves on a medical review committee "shall not be liable for civil damages

tion with his duties on such committee, except those involving wilful or wanton misconduct."

The Illinois General Assembly passed the "Hospital Emergency Service Act" (Senate Bill 1571) this past session and it has been signed into law. Basically, this law permits Illinois hospitals, with the approval of the Illinois Department of Public Health, to conduct pilot programs which utilize trained "mobile intensive care personnel" for the delivery of emergency medical care to the sick and injured at the scene of an emergency and during transport to a hospital. This law specifically provides that no physician who in good faith gives emergency instructions to mobile intensive care personnel at the scene of an emergency, shall be liable for any civil damages, unless issuing the instructions constitutes wilful or wanton misconduct.

AUTOPSY

In a recent Circuit Court of Cook County case, the court held that all relatives in the same class have property rights in the remains of a deceased person, and that each of them should give consent to an autopsy.

Illinois statutes permit authorization of an autopsy by any one member of a class of surviving relatives, unless any other relative with an equal right to make the decision objects, in writing or by telephone or telegraph. In the *Leno* case, however, the Court held the statute to be unconstitutional to the extent that it gives one member of a class of relatives authority to abrogate the rights of other members of the class.

It is unknown whether this ruling will be applied in other cases involving autopsies. Until the questions raised by this decision have been resolved, greater care is required in obtaining consents to autopsies, in order to avoid legal risks.

It is recognized that the performance of autopsies is necessary for maintaining adequate levels of postgraduate medical education in teaching hospitals under internship and residency programs approved by the Council on Medical Education of the American Medical Association. Performance of autopsies is necessary for the maintenance of high standards of patient care under the standards of the Joint Commission on Accreditation of Hospitals. *These necessities may justify the acceptance by hospitals and physicians of some calculated legal risks.*

Where it is virtually impossible to obtain the authorization from all persons who may have a right to decide—either because of the number of persons involved or because of the inaccessibility of some of them—hospitals and physicians may be willing to accept the calculated legal risk. This risk cannot be eliminated entirely, but

it may be minimized to some extent by obtaining the written authorization by one or more adult children of the deceased patient or—if there are no adult children—the written consent of one or more adult brothers or sisters. Two such written consents would be preferable.

Although the calculated legal risk cannot be eliminated, it can be minimized by use of the suggested form found at the end of this article. For maximum protection against legal risks, autopsies should be performed only if consent is obtained from all members of the class of relatives who have the right to make the authorization.

The following is the suggested order for obtaining consent for autopsy:

1. If proper authorization for an autopsy is obtained from the spouse of the deceased patient, this is sufficient.
2. The consent of only one relative is also sufficient where there is no surviving spouse but one adult child, or no surviving spouse, children or parents, but one brother or sister. Where members of the same class of surviving relatives are more than one in number, such as several brothers and sisters, a consent should be obtained from each of them.
3. If there is no surviving spouse—and if there are no children, brothers or sisters of the deceased—consent by both parents of the deceased or by the surviving parent is sufficient.
4. If there is no surviving spouse, but the deceased has had children who either are alive or have died, without themselves having children, then the consent of all living adult children of the deceased is probably sufficient.

CONSENT TO MINORS TO MEDICAL TREATMENT

Birth Control Services for Minors: Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor: who is married; who is a parent; who is pregnant; who has the consent of his parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or who is referred for such services by a physician, clergyman or a planned parenthood agency.

Venereal Disease and Drug Use—Consent to Treat-

ment By Minor: Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs (as defined in the Drug Abuse Control Act), or narcotic drugs (as defined in the Uniform Narcotic Drug Act), may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease. Each incident of venereal disease shall be reported to the State Department

of Public Health or the local board of health in accordance with regulations that may be so adopted. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

CATEGORIES OF MINORS WHO MAY, BY LAW, GIVE CONSENT TO ANY AND ALL MEDICAL TREATMENT

Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that a parent who is a minor may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the

Any physician who provide diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

same powers and obligations as has a person of legal age.

Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July issue of the *Illinois Medical*

Journal. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

On October 1, 1972, P.A. 77-2732 (Illinois Blood Labeling Act) became effective. This Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;
2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or

during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which

there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to which diseases children will be immunized against. This affects the School Code and the Communicable Disease Act.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. Historically, a primary reason for forbidding the use of the corporate form for doctors was that the personal assets of a corporation's stockholders were traditionally beyond the reach of creditors, including persons injured by the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves

from personal malpractice liability.

The corporate form did, however, present certain advantages, particularly in the area of taxation, for which there was no compelling reason to discriminate against professionals. Throughout the past two decades the tax statutes of various professional medical corporations were thrashed out among the Internal Revenue Service, the Federal courts and professionals who claimed that their businesses were entitled to be taxed as corporations. Although many legal questions still remain unresolved,

it is now reasonably certain that physicians in Illinois can take advantage of the corporate form.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages and disadvantages of incorporation. Among the major *advantages* listed, were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

The disadvantages listed by Hanson included:

1. Possible legal costs in defending, to the Internal Revenue Service, the corporate status.

2. An increase of up to 25% for Social Security costs.
3. Corporate franchise taxes.
4. Possible subjection in fact to capital stock and personal property taxes.
5. Increased administrative and legal costs.
6. Increased state income tax payments.
7. State licensing fees.
8. Subjection to a host of State and Federal regulations of corporations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

FORMS

The following forms are submitted for possible use by Illinois physicians. Of course, one's attorney should be consulted where a particular situation appears sufficiently out of the ordinary to warrant a modification of the standard form.

ANATOMICAL GIFT ACT

Illinois law allows an individual to leave his body, or particular parts thereof, for medical science by means of his will or a written statement carried upon his person or found among his effects. The next of kin may also donate all or any part of the body for medical science. The Illinois law, authorizing the above, is set out at Paragraphs 551 through 560 of Chapter 3, Illinois

Revised Statutes, 1971.
The Illinois State Medical Society has prepared forms which may be used by both the donor himself or by the next of kin. Copies of these forms are available at headquarters office in Chicago.

**Anatomical Gift
By a Living Donor**

(1)
I, _____, do hereby give
(2) _____ to
(3) _____ for the following
(4) _____
purpose: _____

IN WITNESS WHEREOF, I have hereunto set
(5)
my hand and seal this _____ day of _____,
A.D. 19____.

(6) _____(SEAL)
Signed, sealed, published and declared by the
(1)
said _____ in the presence
of us, who at his (her) request, in his (her)
presence and in the presence of each other have
hereunto subscribed our names as attesting wit-
nesses, believing him (her) to be of sound and
disposing mind and memory, free from any undue
influence, and to know the objects of his (her)
bounty and affection.
(7)

(7) _____

Instructions

1. Insert name of person making gift.
2. Insert: "my whole body"; or list specific organs and parts to be given.
3. Insert name and address of a physician or a hospital, or a medical institution to receive the gift.
4. Insert: "any purpose authorized by law;" or "a transplantation" or "therapy;" or "research;" or "medical education."
5. Insert date of the signing of this card.
6. Signature of donor.
7. Signature and address of two necessary witnesses.

Anatomical Gift by Next of Kin
Or Other Authorized Person

- I. I (we) are (am) the surviving:
- 1. ☐ Spouse
 - 2. ☐ Adult sons and daughters
 - 3. ☐ Both parents or surviving parent
 - 4. ☐ Adult brothers and sisters
 - 5. ☐ Guardian of the person of the decedent
 - 6. ☐ Person authorized or under obligation to dispose of the body of _____, who died on the _____ day of _____, 19____ in the County of _____, State of _____; and

II. I (we) hereby give:

- ☐ The entire body of the deceased.
- ☐ Any specific organs or parts of the body of the deceased designated by the donee.
- ☐ The following organs or parts of the body of the deceased:

TO: _____
(Insert name and address of a physician; a hospital; or a medical institution) for one of the following purposes:

- ☐ Any purpose authorized by law.
- ☐ A transplantation.
- ☐ Therapy.
- ☐ Research.
- ☐ Medical education.

REQUEST FOR ORAL CONTRACEPTIVE AGENTS

I, _____, hereby request Dr. _____ to prescribe oral contraceptive agents for me.

It has been explained to me, and I fully understand, that the taking of oral contraceptives for contraception or other medical conditions for which their use may be indicated may have an adverse effect on me by the development of side effects in that there is a possibility that the use of such contraceptives may induce a tendency to blood clots, high blood pressure, liver disease, cancer and other diseases or injuries to my person.

Dated: _____, 19_____.

Witness: _____

After considering all of the items set forth above, and the possibility of harmful results from the use of the oral contraceptives, it is still my desire that such oral contraceptives be prescribed for me and I hereby assume any and all risk in connection therewith. I further agree that the said doctor is released from any responsibility in connection with such use by me and no legal action will ever be brought against Dr. _____ due to his prescribing oral contraceptive agents for me.

Patient

AUTHORIZATION FOR AUTOPSY
AND DISPOSITION OF REMAINS

I (We) hereby represent that I am (we are) the (state relationship) _____ of the deceased (name of patient) _____ and that I (we) have the right to control the disposition of the remains of said deceased

IF THE AUTHORIZATION IS SIGNED BY ONE OTHER THAN THE SURVIVING SPOUSE THE FOLLOWING IS TO BE SUPPLIED.

Other surviving relatives are named below:
Adult children: _____

On behalf of myself and the surviving relatives of the deceased (name of patient) _____ including all of those relatives named above, I request and authorize the physicians and surgeons in attendance at the _____ Hospital to perform a complete autopsy on the remains of the deceased (name of patient) _____ and I authorize the removal and retention or use for diagnostic, scientific or therapeutic purposes of such organs, tissues, and parts as such physicians and surgeons deem proper. This authority is granted subject to the following restrictions:

(If no restrictions, write "None.")

- Minor children (Under 18 years): _____
- Father _____
- Mother _____
- Adult brothers and sisters _____
- Minor brothers and sisters (under 18 years) _____

The following special examinations shall be made:

I (We) wish the remains to be released to: _____
(name of undertaking establishment) (city) (state)
Signed _____
Signed _____

Witnesses: _____
Name of person obtaining Authorization: _____
Date _____ Time _____

General Health Services Information

Health services information not listed in this Reference Issue can be obtained by contacting the following:

The Chicago Hospital Council
840 N. Lake Shore Drive
Chicago 60611

Department of Public Health
503 State Office Building
Springfield 62706

Department of Mental Health
State Office Building
Springfield 62706

Department of Children & Family Services
Room 404, New State Office Building
Springfield 62706

Department of Public Aid
618 E. Washington Street
Springfield 62706

Department of Registration & Education
160 N. LaSalle Street
Chicago 60601

Department of Allied Medical Professions & Services
American Medical Association
535 N. Dearborn Street
Chicago 60610

Division of Vocational Rehabilitation
623 E. Adams Street
Springfield 62706

Illinois Hospital Association
840 N. Lake Shore Drive
Chicago 60611

Illinois League for Nursing
2816 N. Ellis
Chicago

Metropolitan Chicago Nursing Home Association
43 E. Ohio Street, Suite 1206
Chicago 60611

Chicago Alcoholism Treatment Center
3026 S. California
Chicago

Illinois Drug Abuse Program
59th & S. Lake Shore Dr.
Chicago 60638

Directories are available for the following:

Child Care Facilities

The Department of Children and Family Services has published a Directory of Licensed Child Care Facilities. This new directory is a quick reference to the services offered by Illinois facilities actively engaged in work with children who are in need of institutional care or other placement services. Included in the directory is basic information about child care institutions, child welfare agencies, maternity centers for minor unwed mothers, and group homes licensed by the Department. The directory is free. Write the Department's Office of Community Relations, 524 S. Second St., Springfield, 62706.

Dentists

American Dental Directory. Available from the American Dental Association, 211 E. Chicago, Chicago, Illinois. Annual. \$25. Lists members and nonmembers, military dentists, dental schools, associations linked to ADA, examining boards, health agencies, state dental organizations, etc. For Dentists, lists name, address, birth year, dental school, degree, specialty, etc.

Osteopaths

Yearbook and Directory of Osteopathic Physicians. American Osteopathic Association, 212 East Ohio Street, Chicago. Annual. \$25 for first copy, \$12.50 each additional copy. Covers both members and nonmembers, colleges, associated osteopathic hospitals. For Osteopaths, lists name, address, birth year, osteopathic school, specialty, etc.

Physicians and Surgeons

AMA Geographic Register of Physicians. AMA, 525 North Dearborn, Chicago. Every 2 years. \$90. Latest volume April, 1970. Covers both members and nonmembers, colleges, etc. For Medical Doctors, lists name, address, birth

year, type of practice, specialty, medical education, license year, boards passed, society memberships, etc.

Podiatrists

Desk Reference, American Podiatry Association, 3301 16th Street NW, Washington, D.C. Annual. About \$25. (Free to advertisers; write "Business office".) Includes alphabetic and geographic listing of podiatrists, affiliated organizations, accredited colleges, therapeutic indices and a catalog of audiovisual, informational and educational materials. For Podiatrists, lists name, address, birth year, podiatric specialty, etc.

Drugstores

Hayes Drugstore Directory. Edward N. Hayes, Publisher, 206 West 4th Street, Santa Ana, California. Annual. \$36 if buy regularly; \$40 one time basis. Lists retail drugstores, estimating volume and credit rating. A list of wholesale druggists is also included.

Internships and Residencies

Directory of Approved Internships and Residencies, AMA, 525 North Dearborn, Chicago. Published in the Fall of the year. Free.

Nursing Homes

U.S. Guide to Nursing Homes. Published by Grosset & Dunlap, Inc., New York City. Each of 3 volumes covers a geographic section of U.S.; \$2.95 per volume. Name and address of home, number of beds, medical services available, recreation and entertainment. (Even a section on how to tell someone they are entering a nursing home without feeling guilty. Perhaps a little too consumerish for some, but very worthwhile for the public relations of nursing homes.)

INDEX TO REFERENCE SECTION

A

Accreditation, Committee on	338
Action Report	355
Administration, Division of	353
Affiliate Societies, Council on	346
Alcoholism and Drug Dependence, Committee on	344
American Medical Association, Delegates and Alternates to	326
American Association of Medical Assistants, Illinois Society	362
Anatomical Gift Act	405
Form for	405
Ancillary Organizations	361
Annual Meeting Joint Management Committee	349
Approved Education Programs, Schools	365
Arbitration, Committee on	343
Artificial Kidney Centers for Acute Poisoning Cases	395
Autopsy	403
Form for	406

B

Bar Association Interprofessional Code, Rep.	351
Benevolence, Committee on Finance and Medical	347
Blood Labeling	404
Board of Trustees, Committees of	346
Bylaws	305
Business Overhead Expense Group Plan	359

C

Chicago Alliance for VD Awareness, Rep.	351
Chicago Medical Society, Officers	332
Certificate of Need, Committee to Study	349
Certified Laboratory Assistants, Approved School of ..	366
Children and Family Services, Department of	373
Director's office	373
Division of— Education and Rehabilitation Services	373
Financial Management	373
Clinical Laboratories, Licensed	393
Comb-1 Insurance Form	355
Committee on Committees	346
Committees— Trustee District	334
(See <i>Specific Committees</i>)	
Constitution and Bylaws	305
Committee on	346
Index to	316
Continuing Medical Education, Illinois Council on	363
Council of Deans, Liaison Committee to the	338
Councils of the Illinois State Medical Society	337
Organization Chart	336
County Medical Societies, Officers of	328
Cytotechnology, Approved Schools of	366

D

Death, Legal Definition, Committee on	342
Delegates and Alternates to American Medical Association	326
to ISMS House of Delegates	327
Direct Reporting Committees	348
District Committees, Trustee	334
Drug Abuse Council of Illinois, Rep.	351

Drug and Therapeutics, Committee on	349
---	-----

E

Ear, Nose and Throat Health Committee on	340
Economics and Peer Review, Council on	337
Education Programs, Approved (Schools)	365
Certified Laboratory Assistants	366
Cytotechnology	366
Histological Technician	366
Medical	366
Medical Record Administrators	366
Medical Record Technicians	366
Medical Technology	366
Nuclear Medicine Technology	366
Nursing	367
Associate Degree Programs	367
Baccalaureate Degree Programs	368
Diploma Programs (Hospital)	369
Practical	370
Physical Therapy	366
Radiation Therapy Technologist	366
Radiologic Technologist	367
Respiratory and Inhalation Therapy	366
Education and Manpower, Council on	338
Educational and Scientific Foundation, Committee on	363
Emergency and Disaster Care, Committee on	345
Environmental and Community Health, Council on ..	339
Ethical Relations Committee	347
Ethics, Principles of Medical	304
Executive Committee	347
Eye Health Committee	341

F

Film	355
Finance and Medical Benevolence Committee	347
Forensic Medicine, Committee on	342
Foundation for Medical Care	364

G

General Health Services Information	407
Governmental Affairs, Council on	341
Division	353
Governmental Health Reimbursement, Committee on	348
Group Disability Program	359
Group Major Medical Expense Plan	359

H

Health Care Delivery, Division of	353
Health Care of the Poor and Rural Problems, Committee on	345
Health Careers Council of Illinois, Rep. to	351
Health Services Information, General	407
Histological Technician, Approved Education Programs	366
Home Health Agency, Illinois Council of, Rep.	351
Hospital Disaster Manual	356
Hospital Income Plan	358
Hospital Patient Records	401
Hospital Satellite, Committee on	345
House of Delegates, ISMS	327
Ex-officio members of	327

I

IDPH/CHP Ad Hoc Planning Committee on	
Paranatal Mortality, Rep.	351
Illinois Controlled Substances Act	402
Illinois Foundation for Medical Care	364
Illinois Interagency Council on	
Smoking and Disease, Rep.	351
Illinois Medical Political Action Committee (IMPAC).....	365
Illinois Medical Student Loan Fund	357
Illinois Regional Medical Program	
Regional Advisory Group	392
Illinois Society, American Association of	
Medical Assistants	362
Officers and Advisors	362
Illinois State Government	372
Department of	
Children and Family Services	373
Mental Health	374
Public Aid	376
Public Health	378
Registration and Education	383
Vocational Rehabilitation Division	391
Executive Branch	372
Legislative Branch	372
Staff Officers	372
Illinois State Medical Society Services	351
Immunization	404
Impartial Medical Testimony	358
INA/ISMS Joint Practice Committee	351
Index to the Constitution and Bylaws	316
Inhalation and Respiratory Therapy,	
Approved Schools of	366
Insurance, Committee on	349
Insurance Form, Comb-1	355
Insurance Programs	358

J

Joint Management Committee, Annual Meeting	349
Joint Committee on School Health, Rep.	351

L

Laboratory Services, Committee on	343
Legal Definition of Death, Committee on	342
Legal Services, ISMS	401
Liability, Limits on	403
Local Health Departments	378

M

Manpower, Subcommittee on	338
Map of Trustee Districts	333
Maternal Welfare, Committee on	340
Medical Corporation	404
Medical and Paramedical Education	365
Medical Assistants, American Association of	362
Medical Career Recruitment Programs	356
Medical Ethics, Principles of	304
Medical Legal Council	342
Medical Legal Information	401
Anatomical Gift Act	405
Autopsy	403
Blood Labeling	404
Hospital Patient Records	401
Illinois Controlled Substances Act	402
Immunization	404

Oral Contraceptive Agcn'ts, Forms	406
Minors to Medical Treatment, Consent to	403
Physician-Patient Relationship	401
Legal Services of ISMS	401
Liability, Limits on	403
Negligence Liability of Physicians	401
Unemployment Compensation	404
Medical Practice Act	383
Medical Record Technicians Librarians,	
Approved Schools of	366
Medical Record Administrator, Approved School of ...	366
Medical Students and Physicians in Training,	
Advisory Committee to	339
Medical Schools in the State of Illinois	365
Medical Technology, Approved Schools of	366
Mental Health, Department of	374
Offices of the Director	374
Divisions	374
Regions and Institutions	374
Non-statutory Boards and Councils	376
Statutory Boards and Councils	375
Mental Health and Addication, Council on	343
Mental Health Facilities, State	375
Midwest Regional Library Association, Rep.	351
Minors to Medical Treatment, Consent to	403
Modern Management of Multiple Births, Film	355
Mutual Fund	358
Multiphasic Testing and Screening	324

N

Negligence and Liability of Physicians	401
Nuclear Medicine Technology, Approved School of ...	366
Nursing,	
Programs Approved	
Associate Degree	367
Baccalaureate Degree	368
Diploma (Hospital)	369
Practical	370

O

Officers	
Chicago Medical Society	332
County Medical Societies	328
State of Illinois	372
On the Legislative Scene	355
Oral Contraceptive Forms	356
Organization Chart, ISMS Councils	352

P

Pediatric Coordinating Council, Rep.	351
Peer Review Appeals Committee	337
Physician Competence, Committee on	350
Personal Life Insurance Program	360
Physician Recruitment Program	357
Physician Recruitment and Student Loan Fund	
Programs	356
Physical Therapy, Approved Schools of	366
Physician-Patient Relationship	401
Poison Control Centers	398
Policy Committee	348
Policy Manual of ISMS	317
Principles of Medical Ethics	304
Professional Liability Insurance Program	360
Public Affairs, Committee on	342
Public Aid, Department of	376

Administrative Staff	376
Advisory Committees	376
Regional officers	376
Public Health, Department of	377
Artificial Kidneys	
for Acute Poisoning Cases	395
Officers of Program Planning	377
Local Health Departments	378
Non-Statutory Boards	381
Licensed Clinical Laboratories	393
Local Health Departments	378
Non-Statutory Boards	381
Statutory Boards and Commission	380
Poison Control Centers	398
Renal Dialysis	394
Facilities, Centers and Directors, Approved	394
Units and Directors, Approved	394
Public Relations and Membership Services, Division of	354
Public Relations and Membership Services, Council on	344
Publications Committee	348
Publications and Scientific Services, Division of	354

R

Radiation Therapy Technologist, Approved School for	366
Radiologic Technologist, Approved Education	
Program For	367
Redistricting and Tenure, Committee on	350
Regional Medical Program	
Regional Advisory Committee	392
Registration and Education, Department of	383
Medical Examining Committee	383
Medical Practice Act	383
Other Examining Boards	391
Relative Value Study Committee	337
Renal Dialysis Centers and Units	394
Retirement Investment Program	358

S

Schools, Approved	
Certified Laboratory Assistants	366
Cytotechnology	366
Histological Technician	366

Medical	365
Medical Record Administrators	366
Medical Record Technicians	366
Medical Technology	366
Nuclear Medicine Technology	366
Nursing	367
Physical Therapy	366
Radiation Therapy Technologists	366
Radiologic Technologists	367
Respiratory and Inhalation Therapy	366
Scientific Speakers Bureau	356
Services, ISMS	351
Services, Legal	401
Social and Medical Services, Council on	343
Special Publications	355
Sports Medicine, Committee on	341
Staff Organization Chart	352
Student Loan Fund Board	350
Swanberg Foundation, Rep. to	351

T

Tax-Qualified Retirement Program	358
Trustee District Committees	334
Trustee Map, Board of	333

U

Unemployment Compensation	404
U.S. Pharmacopoeia, Rep.	351

V

Vocational Rehabilitation, Division of	391
--	-----

W

Woman's Auxiliary	361
Advisory Committee, to the	348
Chairman of the Committees	361
Directors	361
District Councilors	362
Officers	361

Illinois State Medical Society
Annual Meeting
April 3-6, 1974
Conrad Hilton Hotel, Chicago
in conjunction with the
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of the
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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

If there's good reason to prescribe for psychic tension...



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Editorials



Malpractice in the 14th Century

Government regulation of the practice of medicine is not new. Nor are malpractice suits and peer review. Cosman¹ selected seven major legal cases from medieval London documents covering a 150-year period ranging from the mid-14th Century through the late 15th. These were paired with seven minor cases which indicated the theoretical tenets dealing with malpractice. There was a startling relationship between medieval medical and civil authority. By means of medical and surgical guilds, the medieval practitioners achieved reformation of their profession from within and implementation of their regulations from without by powerful municipal and, sometimes, national co-operation.

There were effective procedures for complaints by a patient or his surrogate, by a fellow practitioner, or by a professional organization. Means also were available to handle malpractice insurance and for adjudications of complaint. Bear in mind that this took place in the 14th century.

Expert testimony was left to three master surgeons who were selected by the mayor and aldermen of London. Cosman found the oath and investiture of these three men who were admitted to the position in full ceremonial regalia, in full husting. Under oath the surgeons agreed to faithfully follow their calling, take reasonable payment for their services, and that "they would present to the mayor and aldermen the defaults of others who undertook cures; that they would be ready to attend the maimed and wounded at all times; that they would give truthful information to the officers of the city concerning such maimed, wounded, and others if they be in peril of death."

These doctors were not only expert witnesses but a local PSRO. It was their duty to recognize malpractitioners and report them. They examined questionable cases and reported the results to civil authorities. And the opinions of the

three master surgeons carried a big clout in the English court.

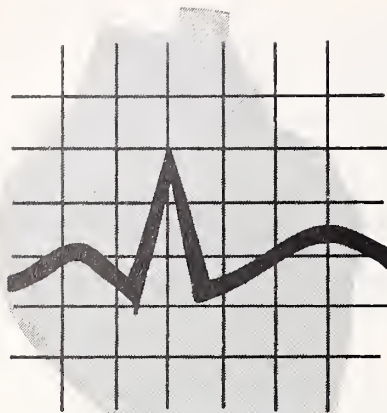
In one of the malpractice cases, the plaintiff had been treated for "an enormous and horrible hurt" of the left side of his jaw. He maintained that if his doctor had called in consultation and assistance to aid him, then the jaw would have been curable. Since he did neither, his lack of skill rendered the injury incurable. The surgeons agreed that since the wounds had been curable and now were incurable, the treating practitioner was criminally to blame. The verdict was guilty!

The false practitioner was a problem in those days. He had false cures and often charged excessive fees. Oddly, the master surgeons promised to scrutinize "other men of their calling and present their defaults to the mayor and aldermen; likewise they will scrutinize all women of their calling and similarly report." This is the first indication of female practitioners in the official English dicta.

In those days, they also had a form of malpractice insurance. When the practitioner agreed to accept a serious case, he had to deposit 20 pounds Sterling with the Chamberlain of London within four days of accepting the high-risk case. In this way the faculty or craft (wardens) of surgeons were notified and acted accordingly. It was a peculiar form of insurance. The practitioner got back the 20 pounds Sterling if something happened and if it was lawfully proved that he acted according to the code. On the other hand, the money was forfeit if it was proved that he acted against the code. Meanwhile, it assured the patient of expert consultation in the master surgeon's examination. ◀

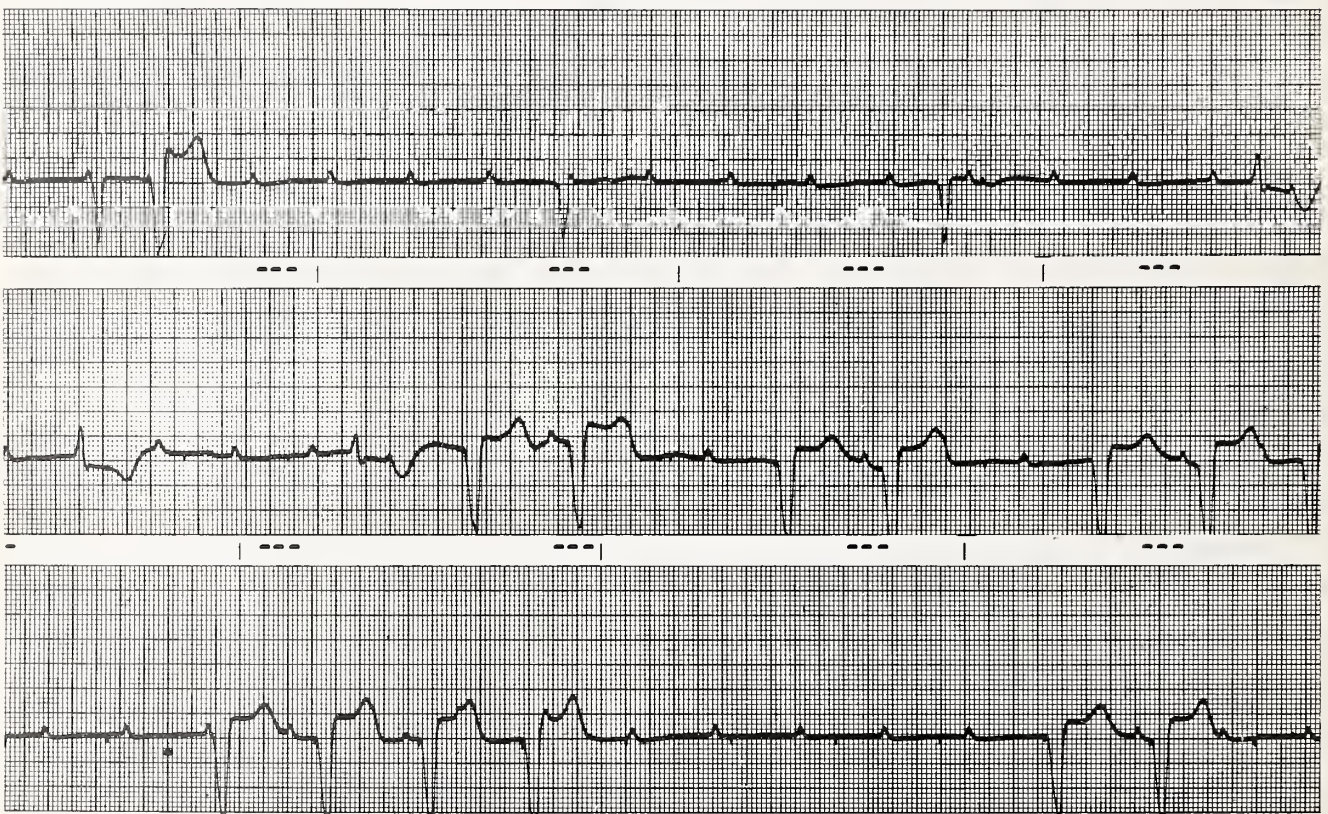
T. R. Van Dellen, M.D.
Editor

1. Cosman, M. P.: "Medieval Medical Malpractice: The Dicta and the Dockets." *Bulletin New York Academy of Medicine* 49:22 (Jan) 1973.



ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine



An 83-year-old female was brought to the emergency room after fainting at home. She denied all prior illnesses including diabetes and hypertension. Her physical exam showed a blood pressure of 140/80, bibasilar rales in her lungs, an increase in jugular venous pressure, a ventricular gallop at the cardiac apex, and a pulse rate of 20 beats per minute. She suddenly became unresponsive, and ventricular fibrillation was diagnosed on the ECG monitor. Successful D.C. cardioversion was performed, and a temporary floating pacemaker was inserted.

The ECG is a rhythm strip from the ECG monitor after the pacemaker was put in place.

Questions:

1. The ECG shows:

- A. Pacemaker failure to sense
- B. Pacemaker failure to capture
- C. Complete heart block
- D. Unstable escape idioventricular beats
- E. All of the above

2. The treatment for this patient should include:

- A. Isuprel intravenously
- B. Digitalis intravenously
- C. Re-positioning the pacemaker catheter
- D. All of the above

(Answers on page 433)

Doctor's News

PHYSICIANS NEEDED TO DO PHYSICALS—The Board of Trustees of the Illinois State Medical Society has gone on record as opposed to paramedics making any conclusion based on data collected by paramedical personnel doing physicals as required by insurance companies and employers. As established by ISMS House of Delegates, there is acceptance of multiphasic health screening services available to a physician. However, interpretation and diagnosis must be under the supervision of a physician.

Since many insurance companies and employers claim that it is difficult to obtain physicians to perform physicals, William M. Lees, M.D., Chairman, ISMS Board of Trustees, wants to hear from those physicians who will perform physicals.

"It is important that the medical profession make available a sufficient number of physicians to guarantee that the public health be protected," remarked Dr. Lees.

Interested physicians are invited to express their views and availability to perform physicals; write to: William M. Lees, M.D., ISMS, 360 N. Michigan Avenue, Chicago, 60601.

IPSRO INTERIM BOARD PROPOSED—Over the last few months, ISMS has taken the lead in the development of an organization which would give representation to all major third-party purchasers, state government, and major provider organizations. The ISMS, which incorporated IPSRO this month, will have the eight members of its' Executive Committee serve on the 17-member interim IPSRO Board.

Other members of the interim board include: the President of the Illinois Foundation for Medical Care, Illinois Hospital Association, Chicago Hospital Council, Health Insurance Council, Blue Cross-Blue Shield, Illinois Association of Osteopathic Physicians and Surgeons, Illinois Nursing Home Association, Illinois Association of Health Care Facilities, and the State of Illinois.

GOVERNOR APPROVES 11 HEALTH BILLS—Last month Illinois Governor Daniel Walker signed 11 health bills. One "key bill" passed was the Lead Poisoning Prevention Act which bans the use of paint containing more than one-half of 1% lead on toys, furniture or interior walls.

Two other important bills appropriate \$500,000 to assist persons requiring kidney dialysis and direct the Department of Public Health to set standards for regional centers providing prenatal and immediate postnatal health care.

Other legislation approved includes: consumers getting at least half of the membership of Blue Cross and Blue Shield Boards and expanding those plans' services; giving community mental health boards more access to local revenue-sharing funds; expanding positions on the state renal disease advisory committees from 11 to 15; and granting the Department of Public Health more power to enforce drinking water and sewage-disposal standards in public places.

TB TESTS NO LONGER REQUIRED FOR PUBLIC SCHOOL EMPLOYEES—Joyce C. Lashof, M.D., Director of the Illinois Department of Public Health, has announced that the state's public school employees will no longer be required to have annual chest X-rays for tuberculosis.

A law which became effective October 1, 1973, exempts all but new school employees from having chest X-rays or tuberculin skin tests to show freedom from tuberculosis.

According to Dr. Lashof the requirement of annual examination for all school employees can no longer be justified since the TB population is at a low level.

48 ILLINOIS PHYSICIANS SERVED IN VIET NAM—During the eight years of existence of Volunteer Physicians for Viet Nam (VPVN) a total of 48 Illinois physicians served in the program. The VPVN program attracted 774 physicians to serve 1,029, two-month tours since 1965. Over 17% of the physicians returned to Viet Nam for more than one tour.

VPVN was renamed "Volunteer Physicians for Viet Nam" in 1966 when the program became the responsibility of the American Medical Association.

LECTURE ON CME AT MARTHA WASHINGTON HOSPITAL—Norman S. Stearns, M.D., senior author of the manual "Continuing Education In Community Hospitals" will be guest lecturer, November 14, 1973, 8:00 p.m. at the Orpheus Club, 1332 W. Irving Park Road, Chicago. Dr. Stearns is Director of Tufts Medical Service at Boston City Hospital in affiliation with Tufts University School of Medicine, Boston.

For information, contact: Fernando Lopez Fernandez, M.D., Medical Director and Chairman, Continuing Medical Education Program, Martha Washington Hospital, 4055 N. Western Avenue, Chicago 60618.

PHYSICIANS IN THE NEWS—New appointments to the medical staff at The Children's Memorial Hospital, Chicago are: **A. Todd Davis, M.D.**, as head of the Division of Infectious Disease at Children's and Assistant Professor of Pediatrics at Northwestern University Medical School and **Emmanuel Shapira, M.D., Ph.D.**, as Visiting Geneticist and as Associate Professor in Pediatrics at Northwestern.

Morton D. Bogdonoff, M.D., has been elected as President of the University of Illinois Hospital Medical Staff.

Hassan Najafi, M.D., is the new Chairman of the Department of Cardiovascular-Thoracic Surgery at Rush-Presbyterian-St. Luke's Medical Center, Chicago.

Pediatrician and lawyer, **Rowine Hayes Brown**, is the first woman to serve as Medical Director of Cook County Hospital.

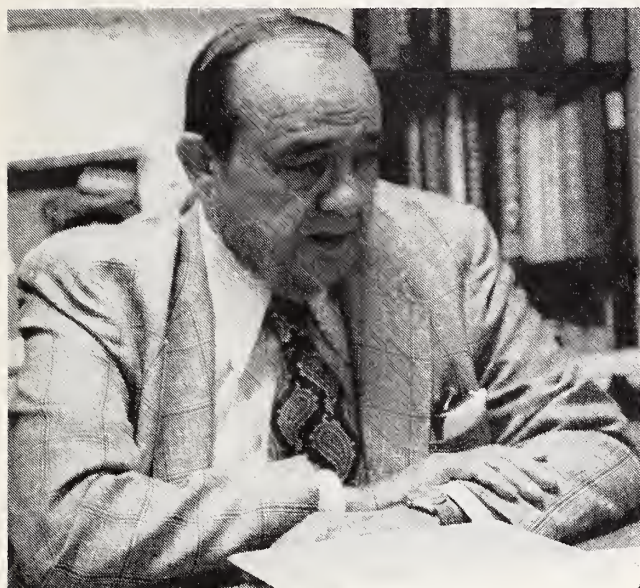
Vlastimil Capek, M.D., recently was appointed as head of the Department of Radiology, University of Illinois, College of Medicine.

The 1973 Loyola Stritch Medal will be awarded to **Capt. Joseph P. Kerwin, M.D.**, next month. Dr. Kerwin, a graduate of Northwestern University Medical School and native of Oak Park, is the first doctor to travel in space. Capt. Kerwin recently served as science-pilot of Skylab-2.

Frank Newell, M.D., Chicago, was recently elected President-Elect of the American Academy of Ophthalmology and Otolaryngology.

Radiologist

Francis E. Bihss, M.D., Honored



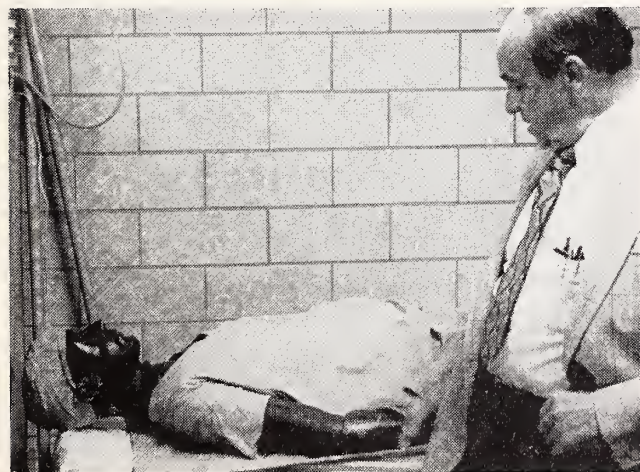
Francis E. Bihss, M.D.

"Being a doctor is not always glamorous—there is always some sadness, but then there is a lot of gratification," commented Francis E. Bihss, M.D., in a recent interview. For Dr. Bihss, who gave up his specialty in obstetrics-gynecology due to a physical condition, has found a most gratifying career as a radiologist and teacher in paramedic training for radiology technicians.

This past summer Dr. Bihss was honored by a "surprise" dedication of the radiology department in his name at the Centreville Township Hospital, a 150-bed hospital in East St. Louis. Dr. Bihss has been at Centreville for 15 years and serves as head of the radiology department.

Dr. Bihss realized the need for training of radiology technicians, so, in conjunction with the Belleville Area College, Dr. Bihss and his staff teach the two-year paramedical program which grants an associate degree upon completion.

Twenty students a year study mornings in labora-



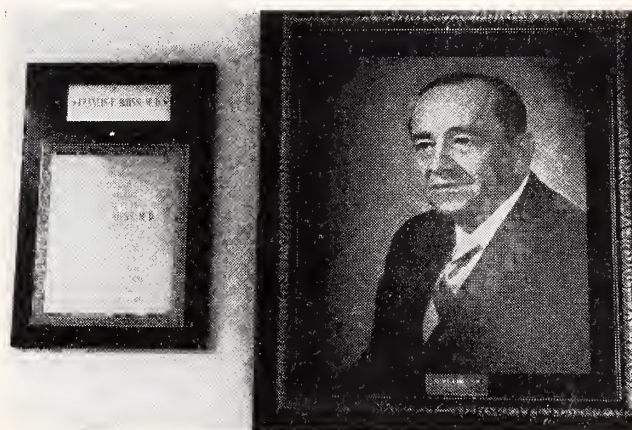
Dr. Bihss stands near the unique 200-pound phantom that assists in teaching radiology technician students.

tory set ups at Centreville and other area hospitals, and then attend classes in the afternoon at Belleville Area College.

One of the unique teaching aides at the Centreville Township Hospital is the 200-pound phantom, which has the same density of a human. Students must pass extensive tests on the phantom before taking X-rays on humans. Dr. Bihss stresses accuracy to his students when taking X-rays, as often in emergency cases it is a "one shot deal." This mannequin, which is thought to be the first one used in teaching radiology technicians, enables less exposure of humans to radiation.

Also part of the curriculum is nuclear medicine and therapy, taught by John Crotly, M.D., stepson of Dr. Bihss. Continuing education courses and refresher seminars are held consistently to keep the technicians abreast on the latest techniques and equipment. This paramedical program has been approved by the American Medical Association, the American College of Radiologists and the Veteran's Administration. The students also may transfer to four-year institutions and receive credit for their studies.

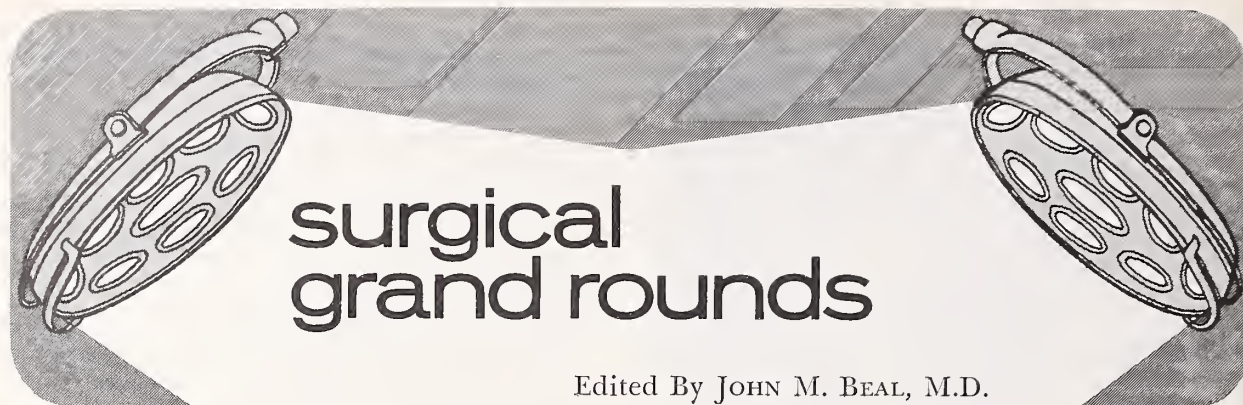
Radiology Technology, written by Dr. L. Santee, is utilized in teaching radiology standards and techniques. Dr. Santee was a former professor of Dr. Bihss' as St. Louis University.



The radiology department of Centreville Township Hospital displays the plaque dedicating the department in honor of Francis E. Bihss, M.D. An oil painting of Dr. Bihss was also presented at the "surprise" dedication on July 5, 1973.

Dr. Bihss maintains a private practice in East St. Louis and Collinsville, and is affiliated at St. Mary's Hospital in East St. Louis. He participates in the St. Clair Medical Society and has served as a delegate to the Illinois State Medical Society House of Delegates.

His primary outside enjoyment is accompanying his wife, Margaret, on her puppet shows. Mrs. Bihss a former school teacher, is a professional puppeteer and performs for children at various hospitals in St. Louis (Mo.) and East St. Louis. Dr. Bihss gives credit to his wife for keeping "her only secret"—the dedication honoring him on July 5, 1973, at Centreville Township Hospital. ◀



Gastric Leiomyoma

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 9, 1973.

Dr. Mark Singer: A 54-year-old Black man was admitted to the Veterans Administration Research Hospital on November 15, 1972. His illness began approximately seven months earlier when he developed hematemesis. He was admitted to another hospital. His evaluation included an upper gastrointestinal series and he was told that he possibly had a duodenal ulcer. His therapy consisted of nasogastric suction, intravenous fluid and transfusion of eight units of whole blood. His hemorrhage was controlled and later a bland diet and anticholinergics were prescribed. The patient did well during the past summer. In November, mid-upper gastric pains occurred which was relieved by the intake of food and by the use of antacids. However, in mid-November, he developed black stools and became fatigued easily. He was admitted to the same hospital again and, once again, hematemesis occurred. Four units of whole blood were required as well as nasogastric intubation. He responded well and operation was recommended for a presumed duodenal ulcer. The patient decided to come to the Veterans Administration Research Hospital for his operation.

Past medical history was not significant. Review of systems: habits include one pack of cigarettes daily, occasional alcohol and no regular medication other than antacids.

Physician examination at the time of admission: he was a well developed, thin Black man who appeared older than his stated age. Blood pressure 120/70 sitting, pulse 100 and regular, temperature 98.6°F. Examination unremarkable. The abdomen was flat and bowel sounds were active. Abdominal tenderness, masses and organs were not felt. Rectal examination was within normal limits.

Laboratory findings: hemoglobin was 12.2 gm, hematocrit 36 per cent. Coagulation studies were normal. Blood urea nitrogen, fasting blood sugar and serum protein were normal. A radiologic study of the stomach was conducted.

Dr. Leonid Calenoff: There are four views of the stomach and duodenum available to us and these are unremarkable. The fluoroscopic examination also failed to demonstrate a lesion in either stomach or duodenum (Figure 1).

Dr. John Beal: Is this an adequate study if one suspects an unusual cause of bleeding?

Dr. Calenoff: The fluoroscopic examination is most important. We would have taken more views of the stomach so that each section of the stomach was carefully examined. We prefer a more detailed study in a patient with a history of bleeding.

Dr. Singer: An additional preoperative test was performed. A 12-hour overnight gastric analysis



Figure 1. The stomach and duodenum appeared to be normal at the time of radiologic study.

was obtained and 200 ml of clear brown gastric fluid was collected which contained 6 milliequivalents of HCl. The preoperative diagnosis was gastrointestinal hemorrhage, recurrent, probably due to duodenal ulcer.

Operation was performed on December 1, 1972, where the abdomen was entered through a right paramedian incision. A six centimeter diameter firm tumor mass was felt posteriorly along the lesser curvature of the stomach. A distal 60% gastrectomy with gastroduodenostomy was performed. The patient had an uncomplicated post-operative course.

Dr. Thomas Harwood: The tumor was on the posterior wall of the stomach and was sub-mucosal in location (Figure 2). It appeared to be well encapsulated grossly. When sectioned, the cut surface bulged, which is fairly characteristic of benign tumors while malignant tumors tend to retract. One area of ulceration was present on the mucosal surface which penetrated about half way into the tumor mass (Figure 3). The tumor did extend from the mucosa all the way to the serosa. When examined under the microscope, the tumor was found not to be truly encapsulated, an important point in differentiation between leiomyoma and neurofibroma. The cells are fairly uniform and regular in appearance, and mitotic figures are absent (Figure 4).

The nuclei are normal in appearance. This has the appearance of a typical leiomyoma of the stomach.

Dr. Alex McGinnis: Several problems are raised by this particular case. First, how does the surgeon determine the nature of a tumor discovered unexpectedly during an operation? Second, what factors must be considered in treating such lesions? Third, is it valid to accept this tumor as the cause of this patient's episodes of severe upper gastrointestinal hemorrhage? Turning to the first question, one can usually determine whether a tumor is benign or malignant by a few simple maneuvers. The likelihood of malignancy correlates partly with tumor size. Lack of invasion of surrounding structures and encapsulation favor benignancy. Evidence of metastases should be sought for and, in this case, was absent. The gross picture was that of a benign gastric tumor in this man. Benign tumors of the stomach can be derived from epithelial tissue or from mesothelial elements. Tumors of epithelial origin include adenomas or polyps, which this obviously was not. Connective tissue tumors include leiomyoma, neurofibroma, lipoma, angioma. Of these, leiomyomas are the most common. The gross appearance of the lesion was typical enough of leiomyoma to warrant treatment with the diagnosis as most likely. Simple excision of a leiomyoma is all that is required to allow removal and to prevent recurrence. In this instance, the location of the tumor resulted in gastric resection. If the lesion had been on the greater curvature, wedge resection would have been adequate. Benign gastric tumors are uncommon when com-



Figure 2. The tumor protruded from the posterior wall of the stomach, which has been opened in this picture.

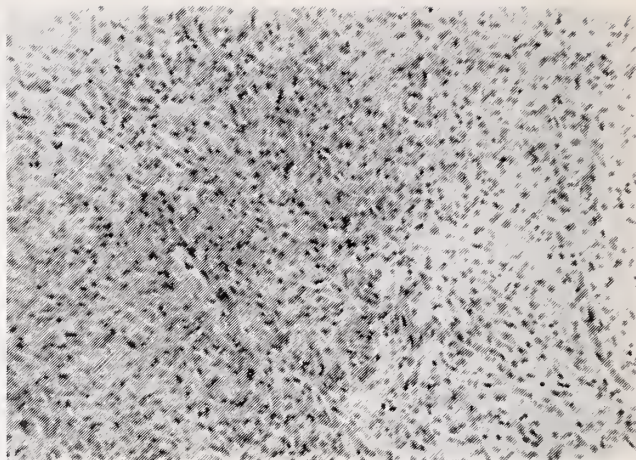
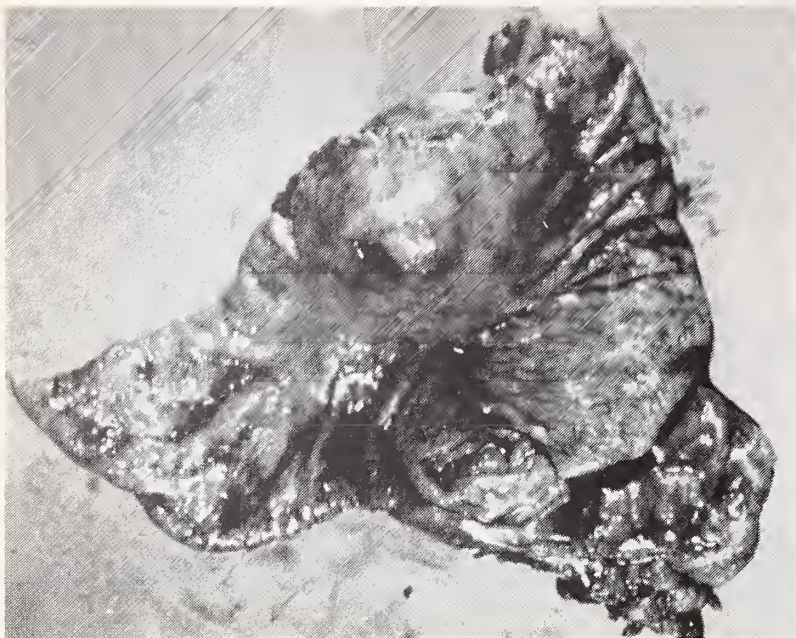


Figure 3. (left) An area of ulceration was found on the mucosal aspect of the stomach and penetrated into the leiomyoma.

Figure 4. (top) The histologic appearance of the tumor was typical of a leiomyoma.

pared to malignant tumors of the stomach. According to most statistics, approximately 100 gastric cancers are encountered for each benign gastric tumor. Hemorrhage is a common symptom of benign gastric tumors and usually occurs only after the tumor has become large enough to undergo central necrosis. Hemorrhage is usually massive in contrast to the slow blood loss associated with gastric cancer.

The patient presented today had characteristic peptic ulcer symptoms prior to his second episode of major bleeding. It is easy to understand why a leiomyoma which ulcerates results in the symptom of pain and then bleeding. The pain is doubtless caused by the gastric acid irritating the ulcerated tumor in the same manner that pain is produced in peptic ulcer. It was valid to accept the tumor as the cause of bleeding because at the time of laparotomy, the duodenum appeared to be normal and a careful examination of the intestinal tract failed to demonstrate any other lesion.

Dr. Beal: The patient that was presented today illustrates at least three significant points concerning gastric leiomyoma. These lesions often bleed. They may not be seen at the time of radiologic study of the gastrointestinal tract and the correct preoperative diagnosis is often not made. Because benign gastric neoplasms are relatively uncommon, they are not a frequent cause of gastrointestinal bleeding. However, when present, these tumors often reveal their presence by bleeding. It is difficult to determine how often gastric neoplasms are a cause of massive gastrointestinal bleeding. In 1970, the Connecticut study of American Board surgeons reported a cooperative study of 296 cases of massive upper gastroin-

testinal bleeding and found that eight patients had suffered massive hemorrhage from gastric neoplasms. One of these was a gastric leiomyoma and another was a leiomyoblastoma. In a study from Boston, Dr. Byrne discussed 172 cases of massive gastrointestinal bleeding and reported a gastric polyp but no leiomyomas among the cases of hemorrhage in his series in 1970.

Benign gastric tumors account for not more than 1% of all gastric neoplasms. Leiomyomas are said to be the commonest benign neoplasm of the stomach. Meisner stated that if a careful search was made, more than half of the stomachs examined will be found to contain leiomyomas. Ackerman conducted a prospective study on autopsy material and found that 23% of the stomachs did indeed contain leiomyomas. Leiomyomas of the stomach are often asymptomatic and may be incidental findings at operation or at autopsy. In a clinical series from Finland, Salmela reported that in one-third of patients, the leiomyoma was an incidental finding. He also noted that leiomyoma was present in 20 of the 64 symptomatic patients. In the series that my colleagues and I reported from New York in 1960, only 9 of 23 leiomyomas produced symptoms clinically.

Symptoms associated with leiomyomas include weight loss, epigastric pain, nausea, abdominal mass, vomiting and anorexia. It has been stated that those smooth muscle tumors of the stomach that give rise to clinical symptoms are more likely to be malignant. A large tumor, tenderness on palpation, weight loss and abdominal pain are suggestive of the presence of malignancy. On the other hand, hemorrhage, which is usually the

(Continued on page 430)

Pediatric Perplexities

Idiopathic Pulmonary Hemosiderosis Anemia and "Pneumonia"

By RUTH ANDREA SEELER, M.D., PEDIATRIC HEMATOLOGIST

COOK COUNTY HOSPITAL AND HEKTOEN INSTITUTE FOR MEDICAL RESEARCH

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Case 1:

B.F., a nine-year-old Black female was admitted with a three-day history of abdominal pain. Two weeks earlier she had developed anorexia and mild lethargy accompanied by fast breathing. She reported to her mother that she had had one black stool. She either vomited or coughed up a "dark red, long, liver-like piece." The mother noted that the child had definite pallor of approximately the same duration as the above mentioned symptoms.

At five years of age she had been admitted because of severe anemia (2.1 grams%) and was extensively studied. A severe iron deficiency anemia was documented and she was started on oral ferrous sulfate. Extensive work-up of the gastro-intestinal tract failed to reveal any focus of bleeding although the stools were positive for occult blood on numerous occasions. She did well for approximately a year; her hemoglobin and hematocrit were known to be normal. At six years of age she again became severely anemic and required packed erythrocyte transfusion. From time to time the child has been noted to have a cough and to be breathing rapidly.

Physical examination revealed a mildly tachypneic pale child of normal height and weight percentiles. The heart had a grade II/VI mid-systolic murmur which was ascribed to the anemia. The lungs were clear. The spleen could be palpated 1 cm below the left costal margin.

The hemoglobin was 2.3 grams percent and



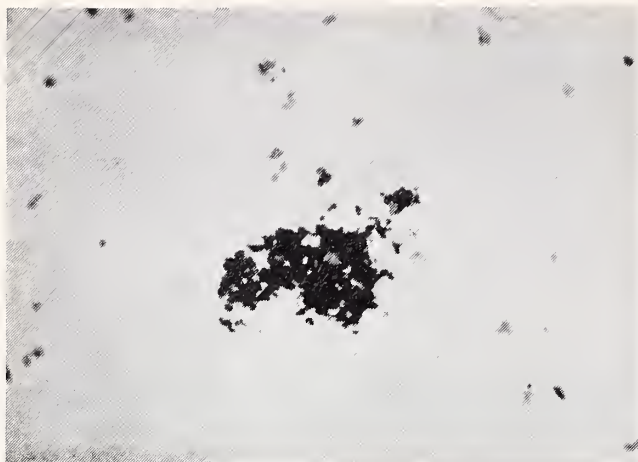
Fig. 1 Chest X-ray showing diffuse infiltrate in the right lung field.

the peripheral blood smear showed marked hypochromia and microcytosis and no eosinophilia. The serum iron was 10 and the total iron binding capacity 690 ug.%. A prompt return of the hemoglobin to normal followed oral iron therapy.

Using the Prussian-blue reaction, the child's sputum was positive for hemosiderin. All of the old chest X-rays were reviewed and many showed areas of haziness. The diagnosis of idiopathic pulmonary hemosiderosis was established. The child has been followed for an additional five years without a further attack.



RUTH ANDREA SEELER, M.D., is the Pediatric Hematologist at the Cook County Hospital. Dr. Seeler received her M.D. degree from the University of Vermont, and then received training in pediatrics and hematology at the Bronx Municipal Hospital and the University of Illinois. Since July 1, 1967 she has been associated with the Cook County Hospital.



Figs. 2, 3 Gastric aspirate stained with Prussian-blue reaction showing hemosiderin laden macrophages. Because of digestion, some cellular detail is lost.

Case 2:

D.B., an 11-month-old Black male was brought to the hospital because of a cough and a temperature of 101°F. The child had a three-month history of a cough and "fast breathing" which many physicians repeatedly diagnosed as an upper respiratory tract infection. The child had one or two episodes of hemoptysis. The chest X-ray showed a bilateral diffuse infiltrate (Fig. 1). The hemoglobin was 9.6 grams% and the hematocrit 27%. The serum iron was 8 ug.%.

The provisional diagnosis of idiopathic pulmonary hemosiderosis was confirmed by gastric aspirate the following morning (Figs. 2 & 3). The chest X-ray rapidly improved and the hemoglobin returned to 11.7 grams% with iron therapy. He was readmitted several weeks later because of another episode of cough tachypnea and fever. The chest X-ray (Fig. 4) revealed new infiltrates. The hemoglobin was 4 grams less than it had been on the last clinic visit and occult blood was present in the stool. Although numerous tests for milk antibodies were negative, he was placed on a milk-free diet.

He has had seven additional episodes, each one accompanied by a decrease of 3 to 4 grams% in the hemoglobin. Prednisone 2 mg/kg per day in three divided doses has been given during the acute period and discontinued within five days. The child has continued to grow and develop normally in height and weight percentiles. The hemoglobin has returned to normal between each of the bleeding episodes.

Discussion

Pulmonary hemosiderosis is an idiopathic, unpredictable disease, where the initial attack can be fatal while other children have a relatively mild course with long remissions.¹⁻¹⁰ With increasing awareness, more children with a milder

form will undoubtedly be diagnosed. Although essentially a disease of young children, approximately 25% of the cases occur in young adults, while occasional cases have been reported in the infant age group.^{1,5,7,9} There is no convincing sex ratio, some studies showing a male, and others a female predominance. It is a sporadic condition in all ethnic groups and without familial or seasonal occurrence.⁹

Although a fulminant form with death during the first attack has been described in infants, children and adults; this is decidedly uncommon.^{1,5-7,9} More typical is a chronic relapsing respiratory disease with intermittent well periods. A nonproductive cough is the initial symptom which, after weeks to months, becomes productive of bloody sputum. In young infants and children, hemoptysis is most unusual. The acute attack is manifest by cough, tachypnea with dyspnea with or without fever, in a patient with variable anemia. Occult blood is sometimes present in the feces and exceptionally rarely melena is present. Hepatosplenomegaly is commonly found and fever and abdominal pain are not unusual. Additionally, jaundice of the indirect bilirubin type frequently is found. What is particularly striking are the relative paucity of physical findings. Although the X-ray reveals extensive amount of infiltrates, there are surprisingly few rales on auscultation.

Characteristically, the X-ray is one of rapidly changing infiltrates in size, density and distribution; usually clearing in one to two weeks. The diagnostic X-ray is that of a bilateral infiltrates originating from the hilum with a "fluffy" distribution. In other patients the hemorrhages may be quite focal, lobar or segmental. After repeated hemorrhages there is a reticular streaking pattern seen throughout the lung fields.⁸

The pathology of idiopathic pulmonary hemo-

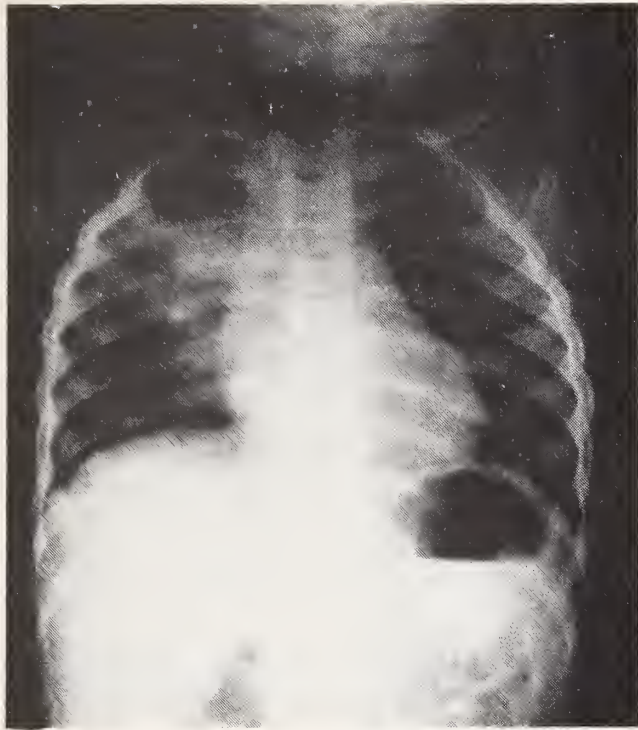


Fig. 4 Chest X-ray with infiltrate in right upper and mid lung field.

siderosis is intra- and interalveolar hemorrhage. Radioisotopic studies show that these patients are always bleeding, but major hemorrhages occur intermittently.^{2,4,9} The blood is phagocytized by the macrophages becoming the "siderocytes" found in the sputum of gastric aspirate. Alveolar degeneration follows the shedding of alveolar epithelial cells. The lung becomes fibrotic with the end stage being right heart failure due to chronic cor pulmonale.⁹

The name of this disorder is "idiopathic pulmonary hemosiderosis" and that says it completely; we simply do not know! When there is no diffinitive etiology, there is an abundance of theories. The reader is referred to an excellent detailed analysis of the various series.⁹ Briefly these include, first, autoantibodies with the lung as the target organ. In some patients an allergic disorder, particularly to cow's milk or other food allergens, has been proved.³ Second, an abnormal vasomotor tone leading to pulmonary hypertension has been postulated. Third, a weakness of the lung elastic-fiber tissue has been postulated. Fourth, an abnormality of the alveolar epithelial cells has been suggested. An intriguing child has been reported recently who survived severe hyaline membrane disease, followed by Wilson-Mikity syndrome and later idiopathic pulmonary hemosiderosis.¹⁰ No matter what the etiology, the fact remains that these patients have hemorrhages into the lung with resultant iron trapping and fibrosis.

A severe iron deficiency anemia is an integral part of idiopathic pulmonary hemosiderosis. Some patients have had hemoglobins as low as 2 grams% or hematocrits of 8%. A reticulocytosis and an increased number of nucleated RBC's on the peripheral blood smear result from both hypoxia and sudden blood loss. In about 25% of the patients there is an eosinophilia. This appears to be variable as some authors stress the eosinophilia while others fail to mention the differential.^{6,8,9} Chromium 51 survival studies reveal a shortened T1/2 due to the lung hemorrhages.^{2,4,9}

The iron deficiency results from the fact that the macrophages which phagocytize the RBC's do not release the iron to transferrin.⁴ Thus, iron becomes stored in the lung and cannot return to the hematopoietic system. In fact, the disease was originally called Brown Lung Disease by Virchow in the initial description in 1864.⁵ Ironically patients need repeated courses of ferrous sulfate in the presence of iron deposition in the lung.

The diagnosis is established by the demonstration of hemosiderin laden macrophages from sputum or gastric aspirate. In adult patients the sputum can be obtained relatively easily. For young infants a gastric aspirate should be done immediately upon awakening. It is important to remember that a gastric aspirate must be done before significant gastric motility takes place. Upon awakening a child is hungry and gastric motility will carry the macrophages into the duodenum. Therefore, it is necessary to awaken the child and immediately do a gastric aspirate. If the child is awake, sitting up and smiling in bed, it is too late to do it that day.

The stain itself is readily available in most hospital hematology laboratories. Sputum is smeared on a glass slide and allowed to dry. Then the Prussian blue stain for hemosiderin iron is applied. Thus, this disease is easy to diagnosis if one thinks of it! Failure to demonstrate hemosiderin laden macrophages in the sputum or gastric aspirate in the appropriate clinical situation should be followed by a lung biopsy.²

Therapy is empiric and may not be rational because the etiology is idiopathic. Splenectomy was tried when the disease was thought to be autoimmune and had no effect.^{8,9} Steroids are favored by most authors for use during the acute bleeding episode.⁶⁻⁹ Some authors recommend that steroids be discontinued after the acute attack subsides, whereas other authors recommend continued once-a-day therapy. Whether one discontinues or continues seems to be a matter of personal choice as no hard data are available. It

is important to note that steroids should *not* be given on a three-times-a-day basis for any extended period of time as this does not alter the course of the disease and is excessively toxic.⁹

In the acute attack frequently it is necessary to transfuse the patient. Prophylactic antibiotics during the acute attack are of no value.⁸ Following the bleeding episode, the patient should be put on oral iron therapy until the hemoglobin is normal.

Because the macrophages of the lung are not in equilibrium with the transferrin mechanism, iron chelation therapy will not be of value.

The problem of evaluating therapy is the intermittency of the severe attacks and the non-predictability of the lengths of remission.^{6,8,9} Some children have one attack and never have another, while others have a rapidly progressive chronic lung disorder. The relative rarity of the disease makes it impossible to make any dogmatic statement as to therapy.

Because of the finding that some of these patients do respond to a milk free diet, dietary control should be attempted.³ It would be tragic to overlook a child whose repeated pulmonary hemorrhages are the result of an allergy to milk. It should be pointed out, however, that the vast majority of children are not milk sensitive.

Prognosis has appeared falsely bleak in that approximately 40-50% of the currently diagnosed patients are dead within five years.^{6,8,9} However, this is probably because only the more severe forms of the disease have been recognized. With increasing awareness, milder forms will be recognized and the mortality rate will be lower.

It is important to consider the possibility of idiopathic pulmonary hemosiderosis in any in-

dividual who has repeated symptoms of "pneumonia" and whose X-ray is read as "pneumonia" if the patient is also severely anemic. ◀

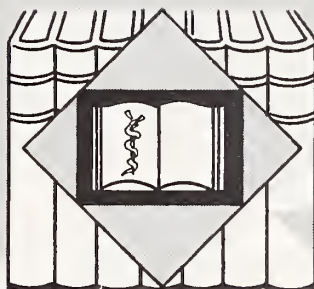
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PHYSICIANS' SYMPHONY SEEKS RECRUITS

Members of the medical and paramedical professions have organized a concert orchestra for pleasure and diversion. A nucleus for a good instrumental group is now rehearsing, according to Walter Spilka, chief organizer of the ensemble, and more players are needed. Doctors or paramedical personnel interested in obtaining information about the orchestra should write to: *Chicago Medicine*, c/o Musician, 310 S. Michigan Avenue, Chicago, Illinois 60604.

the doctor's library



CONTRIBUTION TO NEUROPSYCHOLOGY. Edited by Arthur L. Benton. (Adeline-Atherson Publishing Company, Chicago) 1969.

Clinical neuropsychology is a new field—a paradiscipline developing with unusual speed in the past 25 years. As a result, there is emerging a much clearer, a more advanced understanding, even an interpretation of the complex interrelationship that exists between brain functioning and correlative human behavior.

In this small tome is incorporated contributions from eight of the world's foremost authorities who draw from their findings of their own specific clinical studies their conclusions through animal experimentation, and their other observations all made within flexible approaches. Understandably, each contributor, a widely experienced leader in the field of human and developmental neuropsychology presents his own specific topic of endeavor. Dr. Klaus Preck leads with the chronologic development of the topic of neuropsychology and brings the reader up-to-date on what is new. Both Drs. George Ettlinger and Colin B. Blakemore discuss the behavioral changes both in animals and in humans. After commissural section, Dr. Sidney Weinstein presents neuropsychological studies in humans with "phantom" phenomena. Dr. Norman Geschwind acknowledged as the foremost authority in the field of aphasia, presents his interesting theories of the anatomic approaches to this complex problem. Dr. Arthur L. Benton, the editor of this small book, presents the many unanswered questions concerning constructional apraxia. Next, Dr. Josephine Semmes surveys her thoughts concerning protopathic and epicritic sensation—truly a brilliant presentation and a classic model from which to formulate, and Dr. Luigi A. Vignoli, a pioneering investigator, examines and reviews almost forty years of thinking on auditory agnosia, adding his own thoughts and inclusions of his own research on this major in-

quiry.

This small tome, the subject of a series of lectures by this distinguished group of brilliant investigators more than fulfills its promise of shedding new light on subjects heretofore only theoretic but now more clearly understood through insight developed by productive research.

Louis D. Boshes, M.D.

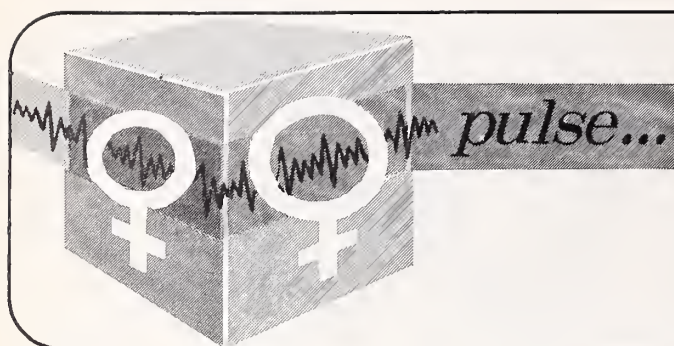
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SYNOPSIS OF SURGERY, 3rd Edition. D. Liechty, M.D. and Robert T. Soper, M.D. (The C. V. Mosby Company).

The new edition of the Synopsis of Surgery should serve as a good introduction to both general surgery and the surgical specialties for the student advancing through the clinical years of medical school. An introductory book of this sort is becoming extremely important with the cut-backs in the amount of time allotted for surgery and the specialties by many of the new curriculum committees. In addition, as the authors point out, the student now must make an early decision as to his long-range future plans for post graduate training. The availability of a book which gives broad coverage to so many areas within surgery will help guide the student as he develops his future plans. In addition, the Synopsis can serve as a starting point for the house officer faced with specific problems in surgery. However, as a synopsis, more detailed knowledge and information in depth will have to come from references included in the text, from time spent exploring specialty texts and reading pertinent journals.

Overall, the Synopsis of Surgery will definitely find a place as a beginning textbook of surgery for students interested in obtaining additional information related to their lectures and seminars in surgery, and for those caring for surgical patients. ◀

Julius Conn, Jr., M.D.



of the doctor's wife

Mrs. ROSANNE K. FRANK, *Editor*

From the Desk of the President...

"Just recovering from that marvelous experience, our ISMS European Adventure"—and that seems to express the feeling of all those with whom we've spoken. Jane Swanson, our Executive Secretary, is still feeling so bubbly about the ISMS trip to the South Pacific almost two years ago (remember?) that she was persuaded to write a short 'highlights' of it to share with all of us. We hope to include that in a future edition of "Pulse." Any one else feel like sharing their impression? Please send it to me.

BUT: if you can't quite make it over there, how about comparing life-styles of medical families from far off places—via the mail? And you can always send along some medical books

or journals to your "pen-pal." You can be "matched up" with someone on the other side of the world, or with a volunteer agency. Did you know that? Just contact:

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What more meaningful way to improve our national and professional images than by showing how much we truly care, by sharing. (Thank you, Mrs. H. L. Warres, Chairman International Health Activities Comm., WA/AMA.)

Mrs. Robert (Bea) Hartman
WA/ISMS President

Board Members Attend Communication Symposium

Four members of the WA/ISMS Board of Directors were in attendance at a Communications Symposium held September 12 in Champaign. The symposium was sponsored by the Illinois Hospital Association featuring Dr. Arthur Hoover, Professor of Business Administration, Southern Illinois University, as the guest speaker.

Mrs. Harlan Failor, Champaign; Mrs. William Schowengerdt, Champaign; Mrs. Kenneth Furlong, Peoria and Mrs. Robert Hartman, Jacksonville, found the morning session of interest which covered "getting together the planning committee." They learned that for a true balance planning committees should be composed of a pusher-leader, a conserver, an artist, a fact-finder and a reflector-definer. These categories could be combined in several individuals, and the chairman could be any one of the individuals described.

Also discussed was the task of programming an activity. The 150 ladies in attendance at the symposium were advised to begin planning some events as early as six months in advance; gather records of past events; calendarize for the year and have records of on-going programs and special events in each community; and to evaluate.

WA/ISMS
Winter Board Meeting
January 7, 1974
Chicago-Sheraton



“Orientation USA” is in session as St. Joseph’s Hospital, Chicago. Instructing foreign medical graduates about the American culture are (from left to right) Mrs. Gustave Tufo, Mrs. Joseph Shanks and Mrs. Mitchell Spellberg. The volunteer instructors are members of the Chicago Medical Society Woman’s Auxiliary.

CMS Auxiliary Helps Foreign Physicians

The Chicago Medical Society Woman’s Auxiliary has developed an “Orientation U.S.A.” program for foreign medical graduates newly arrived in the United States. Mrs. Joseph Shanks, Chairman of Educational Services, reports that this is their fourth annual program being given at St. Joseph’s Hospital in Chicago. The short, intensive course is instituted immediately after a arrival, with the aim of improving his/her knowledge of our language, customs and culture. As language competency improves, communication with colleagues and patients is enhanced. The course lasts for six weeks, but they have organized a follow-up which includes social contact between fellow doctor’s wives, and in general keep in touch to help with problems or questions. It has definitely given dividends in contributing to patient care, and helped the physician gain more from his experience in this country.

In addition to Mrs. Shanks teaching the program, other volunteers include: Mrs. Mitchell Spellberg, Mrs. Herbert Cibul and Mrs. Gustave Tufo.

Notes from the Editor . . .

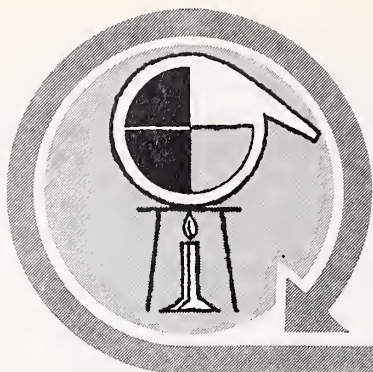
AMA-ERF: News release from the WA/AMA

can give you a lift the next time someone asks you what the auxiliary accomplishes—the CONTRIBUTION made by national auxiliary at the convention this summer, for AMA-ERF activities was \$965,256.27! That is almost ONE MILLION DOLLARS! This represent the efforts of every single auxilian in every single auxiliary. *Membership:* Mrs. Glatter, WA/ISMS President-elect and Membership Chairman is *ALL OUT* for new members—so get ready with ideas, names of prospects for your county auxiliary.

Get Ready For . . . **Feb. 3-6: Washington Roundup.** A chance to skip off to meet government cabinet members, hear some exciting talk. Not to mention the special charter trip planned to the Dutch Antilles, February 6-13, which leaves Chicago on the 6th, and stops to pick up ISMS members at the Roundup in Washington. A chance to KEEP INFORMED on proposed legislation, and HAVE FUN, too!

Feb. 28, 1974: WA/ISMS Auxiliary Health Education Conference at the La Salle Hotel, Chicago. Mrs. Betty Pitcher’s generous gift, plus co-sponsorship of the ISMS should make this a good meeting. Lots of help will be needed from auxilians, so mark your calendars.

April 1-3, 1974: Quality of Life Congress on Aging, in Chicago, followed by the **WA/ISMS Annual Convention, April 3-6, 1974.**



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

BENISONE GEL Topical Corticoid R

Manufacturer: Warner-Chilcott Laboratories

Nonproprietary Name: Betamethasone Benzoate

Indications: Symptomatic relief of inflammatory manifestations of the skin.

Contraindications: Varicella and vaccinia, not for ophthalmic use. Hypersensitivity to corticosteroids.

Precautions: See package insert.

Dosage: Apply to affected areas 2 to 4 times daily as needed.

Supplied: Tube 25 and 60 mg.; 0.025%

BLENOXANE Cancer Chemotherapy R

Manufacturer: Bristol Laboratories

Nonproprietary Name: Bleomycin Sulfate

Indications: Adjuvant therapy in squamous cell cancers; Hodgkin's disease, other cancers of the lymphatic system, and testicular tumors.

Contraindication: Hypersensitivity to the drug.

Precautions: Preferably given to hospitalized patients; extreme caution in patients with significant impairment of renal function or pulmonary function.

Dosage: Varies with disease treated; follow instruction in package insert.

Supplied: Ampules; 15 units bleomycin sulfate

METHOSARB Cancer Chemotherapy R

Manufacturer: The Upjohn Company

Nonproprietary Name: Calusterone

Indications: Palliative therapy of advanced inoperable or metastatic carcinoma of the breast in postmenopausal women.

Contraindications: Carcinoma of male breast and premenopausal women.

Precautions: Those general observed with androgens.

Dosage: 50 mg. q.i.d., although doses of 150-300 mg. day have been successfully prescribed.

Supplied: Tablets, 50 mg.

PONDIMIN Antiobesity Preparation R

Manufacturer: A. H. Robins Company

Nonproprietary Name: Fenfluramine HCl

Indications: Short-term management of exogenous obesity, producing more CNS depression than stimulation.

Contraindications: Glaucoma and hypersensitivity to fenfluramine.

Warnings and Precautions: Refer to package insert

Dosage: Initially—one tablet t.i.d. before meals, then adjust to patient's response.

Supplied: Tablets; 20 mg.

DUPLICATE SINGLE DRUGS

CLOR-PZ Tranquilizer R

Manufacturer: USV Pharmaceutical Corporation

Nonproprietary Name: Chlorpromazine HCl

Indications: Management of manifestations of psychotic disorders and for control of nausea and vomiting.

Contraindications: Comatose states, presence of large amounts of CNS depressants and bone marrow depression.

Dosage: 10 to 25 mg. t.i.d. or q.i.d., depending on patient's response.

Supplied: Tablets, 10, 25, 50, 100 and 200 mg.

FLUOGEN-B Biological R

Manufacturer: Parke, Davis & Company

Nonproprietary Name: Influenza Virus Vaccine, Monovalent, B/Hong Kong/5/72.

Indications: Prevention of virus influenza

Contraindications: Hypersensitivity

Dosage: 0.5 cc.

Supplied: Vials 5 cc.; 55 CCA units/0.5 cc.

HYDROCORTISONE ACETATE

in Orabase Oral Base Topical Corticosteroid R

Manufacturer: Davies Rose Hoyt

Nonproprietary Name: Hydrocortisone Acetate

Indications: Adjunctive relief of oral inflammatory lesions and ulcerative lesions resulting from trauma.

Contraindications: Fungal, viral or bacterial infections of the oral mucosa. Hypersensitivity to corticoid steroids. Not for ophthalmic use.

Precautions: Those usual for corticosteroids.

Dosage: Dab on the lesion until paste adheres; 2 or 3 times daily.

Supplied: Tubes 5 gm., 0.5%

PROPOXYCHEL Analgesic R

Manufacturer: Rachele Laboratories, Inc.

Nonproprietary Name: Propoxyphen HCl

Indications: For the relief of mild to moderate pain.

Contraindications: Do not use in children; use with circumspection in pregnancy.

Precautions: Tolerance has been reported in some patients.

Dosage: 65 mg. t.i.d. or q.i.d.
Supplied: Capsules 65 mg.

WESTADONE Narcotic R

Manufacturer: The Vitarine Co., Inc.
Nonproprietary Name: Methadone HCl
Indications: Detoxification treatment of narcotic addiction. Maintenance treatment of narcotic addiction.
Contraindications: Hypersensitivity to methadone.
Dosage: See package insert
Supplied: Effervescent tablets, 2.5, 5, 10 and 40 mg.

COMBINATION PRODUCTS

BACTRIM Urinary Tract Infections R

Manufacturer: Roche Laboratories
Composition: Trimethoprim, 80mg. (New single drug)
Sulfamethoxazole, 400 mg.
Indications: Chronic urinary tract infections due to susceptible organisms.
Contraindications: Hypersensitivity to the drug; pregnancy and during nursing period.
Precaution: Use with caution in patients with impaired renal or hepatic function, those with possible folate deficiency or with severe allergy or bronchial asthma. Do not give to children under 12 years of age.
Dosage: Two tablets every 12 hours for 10 to 14 days.
Supplied: Tablets

CAMA Analgesic o.t.c.

Manufacturer: Dorsey Laboratories
Composition: Aspirin 600 mg.
Magnesium hydroxide 150 mg.
Aluminum hydroxide dried gel 150 mg.
Indications: Relief of pain in arthritis and rheumatism.
Contraindications: Hypersensitivity to aspirin
Dosage: 1 to 2 tablets q.i.d.
Supplied: Inlay tablets

PRINCIPEN w.

Probenecid Pack Antibiotic R
Manufacturer: E. R. Squibb & Sons
Composition: Capsules—Ampicillin trihydrate 500 mg.
Tablets—Probenecid 500 mg.
Indications: Uncomplicated gonorrhea
Contraindications: Hypersensitivity to penicillin or probenecid.
Precautions: Follow up cultures 7 to 14 days after single dose.
Dosage; single: Ampicillin 3.5 mg. (7 capsules)
Probenecid 1.0 gm. (2 tablets)
Supplied: Seven capsules, ampicillin
Two tablets, probenecid

SEPTRA Urinary Tract Infections R

Manufacturer: Burroughs Wellcome Co.
Composition: Trimethoprim 80 mg. (New single drug)
Sulfamethoxazole, 400 mg.
Indications: Chronic urinary tract infections due to susceptible organisms.
Contraindications: Hypersensitivity to the drug; pregnancy and during nursing period.
Precaution: Use with caution in patients with impaired renal or hepatic function, those with possible folate deficiency or with severe allergy or bronchial asthma. Do not give to children under 12 years of age.

Dosage: Two tablets every twelve hours for 10 to 14 days.
Supplied: Tablets

NEW DOSAGE FORMS

DERMACORT LOTION Topical Corticosteroid R

Manufacturer: Rowell Laboratories, Inc.
Nonproprietary Name: Hydrocortisone
Indications: Symptomatic relief of inflammatory manifestations of the skin.
Contraindications: Hypersensitivity to corticosteroids.
Precautions: See package insert
Dosage: Apply to affected areas 2 to 4 times daily as needed.
Supplied: Lotion, 0.5%

TOPSYN GEL Topical Corticosteroid R

Manufacturer: Syntex Laboratories, Inc.
Nonproprietary Name: Fluocinonide
Indications: Symptomatic relief of inflammatory manifestations of psoriasis.
Contraindications: Varicella and vaccinia, Hypersensitivity to corticosteroids.
Precautions: See package insert.
Dosage: Massage into affected area 3 or 4 times daily.
Supplied: Gel, tubes of 15 and 60 gm.; 0.05%
Note: Fluocinonide cream marketed as LIDEX

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Grastric Leiomyoma

(Continued from page 420)


result of central necrosis or erosion of the tumor, as Dr. McGinnis has stated, is not helpful in differentiating between benignness and malignancy. Sometimes the histologic picture is difficult for the pathologist. Radiologic study of the upper gastrointestinal tract may present findings typical of gastric leiomyoma but may be misleading or not diagnostic. In our 1960 study, roentgenograms of upper gastrointestinal tract provided the correct preoperative diagnosis in only one patient, and was reported to be normal in another. In the series of 70 patients who were subjected to upper gastrointestinal X-rays in the Finland studies, the radiologic study failed to demonstrate a tumor in 22 patients. In 18 others, the lesion demonstrated was thought to be of carcinoma. It may be concluded that leiomyomas

of the stomach are associated with diagnostic difficulties. The symptomatology which may resemble pyloric obstruction or bleeding is similar to that encountered with other neoplasms of the stomach.

Dr. Gabriel Lorenzo: A word should be said when the leiomyoma is an incidental finding at the time of operation. In general, an attempt should be made to excise the leiomyoma with a good margin of normal tissue rather than to enucleate the tumor. If the patient's condition is precarious from the primary problem, the presence of the lesion should be noted so that a second operation can be performed at a later time. ◀

Bibliography

1. Grafe, W. R., Thorbjarnarson, B., Pearce, J. M. and Beal, J. M.: Benign Neoplasms of the Stomach." *Am. J. Surg.*, 100:561, 1960.
2. Salmela, H.: "Smooth Muscle Tumors of the Stomach." *Acta. Chir. Scand.*, 134:384, 1968.



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membership forum

Friends and Colleagues in Illinois:

For 12 years, as Director of the Illinois Department of Public Health, it was my pleasure to work with the officers, members and staff of the Illinois State Medical Society.

I extend my deep appreciation to all physicians of Illinois and other colleagues on the health team for their support of public health programs. It is the total cooperation of the health team that raises the level of health for the individual citizens.

Mrs. Yoder and I are grateful for many courtesies. As we take up residence in Colorado, we will fondly remember the many friendships we have back in Illinois

Yours sincerely,
Franklin D. Yoder, M.D.

Editor's Note: Dr. Yoder is the new Director of the Weld County Health Department, 1555 17th Ave., Greeley, Colo.

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3 Days, Nov. 8
SURGERY OF GASTROINTESTINAL TRACT, One Week, November 12
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 29
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 26
BASIC ELECTROCARDIOGRAPHY, One Week, October 15
BASIC INTERNAL MEDICINE, One Week, October 22
ADVANCES IN INTERNAL MEDICINE, One Week, Nov. 26
FAMILY PRACTICE REVIEW, One Week, October 8
PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 30
RECENT ADVANCES IN PSYCHIATRY One Week, December 3
STATE & NATIONAL BOARD REVIEW, Basic & Clinical,
Nov. 4 & Nov. 12
GENERAL PEDIATRICS, One Week, November 26
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EKG of the Month

(Continued from page 414)

Answers: 1. B,C,D 2. C

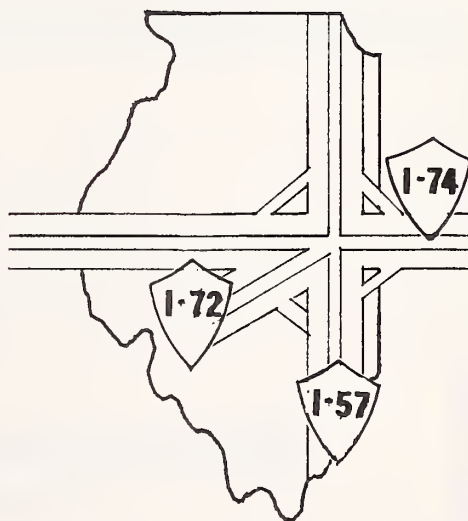
The ECG rhythm strip shows long periods of complete A-V block as well as at least two escape ventricular foci; beats 1,3,4 and 5 in line 1 and beats 1 and 2 in line 2. Neither focus is persistent enough to maintain a reasonable heart rate. The second beat in line 1, the third through ninth beats in line 2, and all the beats in line 3 are pacemaker capture beats. There are small pacemaker artifacts seen in all of the rhythm strip which fail to capture the ventricles. This could be handled by re-positioning the pacemaker catheter to insure more consistent ventricular capture.

Isuprel might not be a good choice here because it could aggravate the ventricular irritability. Digitalis alone could worsen the A-V block. Subsequently a permanent demand pacemaker was successfully implanted. The ventricular irritability seemed to be related to the severe bradycardia. Once the demand pacemaker was functioning well, digitalis could be given if needed for any heart failure. ◀

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Southern Illinois Medical Association Hosts Annual Meeting in November

The 99th Annual Meeting of the Southern Illinois Medical Association will be held November 8, 1973, at the Belle-Clair Fairgrounds Convention Center, Routes 159 & 13, Belleville. Registration begins at 8:00 a.m.

The morning speaker will be V. Pillay, M.D., Associate Professor of Medicine, University of Illinois, Abraham Lincoln School of Medicine. Dr. Pillay's topics will be "Renal Disease in Pregnancy" and "Diabetes and Thyroid Dysfunction in Gestation."

A panel discussion on "Electrolytes and Fluid Balance" will be featured in the afternoon session. C. Veremakis, M.D., Chief of Anesthesiology, Belleville Memorial Hospital will serve as moderator. Panelists are Robert J. Baker, M.D., Professor of Surgery, University of Illinois Abraham Lincoln School of

Medicine and Dean, Cook County Graduate School of Medicine and William A. Knight, M.D., Director of Medicine, St. Mary's Health Center and Professor of Medicine, St. Mary's Health Center.

Warren D. Tuttle, M.D. and Herbert P. Dexheimer, M.D., Trustees to the Illinois State Medical Society from Districts 9 & 10 respectively, will host a discussion period. A business meeting of SIMA will follow the district discussion.

A banquet closes the one-day annual meeting.

Officers of SIMA are: President, R. E. Schettler, M.D., Red Bud; First Vice President, Joseph A. Werth, M.D., Waterloo; Second Vice President, A. R. Esposito, M.D., Murphysboro and Executive Secretary-Treasurer, William H. Walton, M.D., Belleville.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (10)

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington, 61701, 309-828-6051. (1)

BLUE ISLAND: Gastroenterologist, Ophthalmologists and Otolaryngologist urgently needed in this south suburban community. City of approx. 20,000, but hospital and clinic serving approx. 250,000. Pronger-Smith Clinic, old, well-established clinic in beautiful new building. Generous starting salary. Contact: Gerald A. Caress, 2320 W. High St., Blue Island, 60406, 312-388-5500. (2)

BRADLEY: Looking for replacement (male or female) in my general practice. Fully equipped including competent personnel. Open staff hospital privileges. Leaving for health reasons. Trade area of 90,000, 60 miles south of Chicago. Write Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CHICAGO: Opening in welfare clinic, south side; no hospital work. Guaranteed salary. Good opportunity to work into a part-ownership. Contact: Robert C. Parro, Chicago Medical Center, Inc., 657 W. 79th St., Chicago, 60620, 312-994-0100. (11)

CHICAGO: The Cancer Prevention Center, a multi-phasic health screening facility, seeks internists, surgeons, gynecologists for its comprehensive health examinations. Employment is part time. Interested physicians are invited to visit and apply. Please contact the office of Angelo P. Creticos, M.D., 33 W. Huron, Chicago, 60610, 312-944-4371. (11)

CHICAGO: Internist; an insurance company has an opening for the position of staff physician in its medical department. Full-time, fringe benefits, salary negotiable, office population. Contact: Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CLINTON: General Practitioners needed for rural community. Population 8,000. 50 bed JCAH hospital. Located 25 miles from Bloomington and Decatur and 40 miles from Springfield. This community offers good schools and educational opportunities, recreational areas, and shopping areas within a short distance. Medical Staff needs your help. Contact: Dr. Charles Ramey, 215 East Main Street, Clinton, 61727, 217-935-2191. (12)

DANVILLE: Population 45,000; Drawing area more than 100,000. Primary need in General Practice-Family Physician, however many specialties also required. Excellent hospital facilities; many specialties well represented. Fine community, affiliation with the University of Illinois Medical School available. Office space available. Contact: W. N. McCormack, M.D., 812 N. Logan Avenue, Danville, 61832, 217-443-5362. (11)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D., 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

GALENA: Pop. 4,000. Family/General Practitioner needed to join three other FPs. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 80,000. Historical community offers very good school systems, numerous churches, and outstanding recreational facilities. Contact: Wilbur E. Johnson, M.D., 300 Summit Street, Galena, 61036, 815-777-0900. (11)

GENEVA: GP's or Internists, outstanding area with unlimited practice opportunities needs you to grow with us. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "New England" background—and all only 35 miles from the cultural and medical education advantages of Chicago. Contact: Peter G. Gilbert, M.D., c/o Community Hospital, Geneva, 60134, 312-232-0771. (2)

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HOOPESTON: Organizing medical group, looking for obstetrician, internist, and general practitioner. Trouble free community of 8,000; stable economy, drawing area of 25,000. Well established practice. Contact: E. P.

Kosyak, M.D., 847 E. Orange St., Hoopeston, 60942, 217-283-5557. (12)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (11)

MACON: Thriving community of 1600. Five of seven nearby towns without resident physician. Adequate unfurnished building available. Assistance given to become established. Located 8 miles south of Decatur (two first-class hospitals). Excellent schools. Five churches. Contact: Olive Johns, 250 W. Ruby St., Macon, 62544, 217-764-3483. (11)

MINONK: Population 2,500. Serving a patient area of over 10,000. Opening in new Medical Clinic, Inc. Twenty-five miles from two Universities in Bloomington and in Peoria. Schools, churches and facilities nearby. Contact: H. T. Barrett, M.D., 200 E. Sixth St., Minonk, 61760, 309-432-2525. (10)

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265. (11)

OTTAWA: Population 20,000. 75 minutes from Chicago loop via Interstates. Completely equipped ground floor physicians office with adjacent parking space. Enjoy good living and recreation as well as congenial professional relationships. Entirely new 125 bed hospital due to open this October. No traffic, no smog, just excellent family living. Contact: E. R. Maierhofer, M.D., 226 W. Madison St., Ottawa, 61350, 815-434-7418. (12)

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SOUTHERN ILLINOIS: Southernmost Illinois Health Care Planning Council—Represents 76,000 population in southern Illinois, with 4 hospitals in the area. Picturest southern Illinois is proud of its recreational facilities, schools and Southern Illinois University within commuting distance. Office space and housing available. Contact: Ray Oxford, Planning Director, 421 N. Blanche Street, Mounds, 62964, 618-745-6528. (12)

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WENONA: General Practice Opening. Population 1,200. Several nearby communities without physicians. Only physician wanting to retire soon because of health. 15 miles from new St. Mary's Hospital at Streator. Office space and financial assistance available. Excellent schools. Contact: William Gilman, M.D., 407 1st North St., Wenona, 61377, 815-853-4511. (10)

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December 2, 1973

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FOR FURTHER INFORMATION — CONTACT:

Physician Recruitment Program
Illinois State Medical Society
360 North Michigan Ave.
Chicago, Ill. 60601

Obituaries

***Belting, John T.**, Charleston, died August 20 at the age of 81. He was a graduate of the University of Illinois College of Medicine in 1924, after which he practiced medicine in Charleston for 37 years as a physician and surgeon. He was a senior physician on staff of the Charleston Community Memorial Hospital. During his medical career he was past-president, Coles Cumberland County Medical Society and past chief of staff, Charleston Memorial Hospital.

***Iknayan, Herbert A.**, Charleston, died August 21, at the age of 64. He was a graduate of Washington University, St. Louis, in 1940. Dr. Iknayan practiced medicine in Charleston before entering the Army Medical Corps in 1942, where he served for three years overseas. In 1945, he resumed private practice in Charleston. He also was past chief of staff at Charleston Memorial Hospital.

***Kersey, George**, Chicago, died August 25, at the age of 66. He was an obstetrician and surgeon at Provident Hospital for 37 years.

****Marcus, Walter**, Chicago, died July 28, at the age of 79. He graduated from the University of Hessen, Germany, in 1923. Dr. Marcus had practiced medicine for 50 years.

***Miller, Wilfred S.**, Assumption, died August 24, at the age of 74. He was a member of the medical staff of Decatur Memorial Hospital and had served on the Board of Directors of Findlay College in Ohio. He was a graduate of Rush Medical College.

****Segal, Charles**, Glencoe, died August 14, at the age of 91. He was a graduate of the University of Illinois, 1907. He had practiced medicine for more than 50 years.

Weil, Ann Pollack, Sauk Village, died August 15, at the age of 77. She was associated with the Michael Reese Hospital and Chicago College of Osteopathic Medicine.

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Positions & Practice Opportunities

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WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

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INTERNISTS: Prefer Bd. Cert. or Bd. eligible, opportunity for private, group practice. Offices, hospital based, newly constructed, plus renovated 200 bed, fully accredited acute care community hospital. Low overhead. Contact Administrator, Loretto Hospital, 645 S. Central Ave., Chicago, Ill. 60644. (312) 626-4300.

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ASSISTANT MEDICAL DIRECTOR—IDS Life, a subsidiary of Investors Diversified Services, is seeking an internist or general practitioner. This is an administrative position on the Minneapolis home office staff of a rapidly growing life and disability income insurance company. Primary responsibility is for the medical evaluation of insurance applications. Ability to interpret electrocardiograms is required. Position offers advancement potential, excellent benefits, profit sharing, and expenses for relocation to Minneapolis. Send resume in confidence to Dan Willius, 3300 IDS Tower, Minneapolis, Minnesota 55402.

Positions & Practice Opportunities (Con't)

FAMILY PRACTICE OPENING—January, 1974 in two man office. Cashmere, Washington, outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Washington 98815.

LARGE EMERGENCY DEPARTMENT GROUP that covers 14 hospitals in North Central Illinois needs full-time **PHYSICIANS**. Flexible scheduling. Group advantages; Good salary with fringes. General Medical Services, Ltd., 153 W. Lake Street, Bloomingdale, Illinois 60108. Phone 312-627-3404.

WANTED: RECENTLY TRAINED RADIOLOGIST to provide modern diagnostic and therapeutic radiological services for a recently consolidated midwest regional hospital of approximately 300 beds. Radiologist recently expired and his part time associate plans to retire soon. Reply to P.O. Box 821 c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

OPENING FOR GP, OB-GYN and PEDIATRICIAN in well-established group practice west suburb of Chicago. Fully-equipped Lab. and X-ray. Topnotch hospital within three miles of office. Negotiable. P.O. Box No. 822, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS—Welfare area in need of physicians. Please contact: Mr. Robert Fields 312-236-2555.

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PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone 815-725-1188.

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

FOR RENT: Suites available in a recently completed Medical Center just 1/2 Mile from the new proposed Hospital in Barrington, Illinois. Each suite, 800 sq. ft., is elegantly finished and absolutely independent, incl. W/R, A/C, AM-FM, etc. Ample parking. Reply Box Number 815, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

Office Space Available, **4010 W. MADISON STREET, CHICAGO, ILL.** 1-2-3 Rm. Suites or larger, in first class fireproof heated building. Good cleaning service. Automatic elevators. Plenty of business here for Doctors or Dentists etc. Immed. Poss. Contact: R. M. Ryan Realtor Agent, phone: (312) 243-2727 or apply Office of Building.

FOR SALE: MINI-CLINIC (17 Rooms) 6545 North Ave., Oak Park, Ill. Quality one-story medical building—3 Deluxe suites. X-ray Room—Drug Room—Laboratory—Central air-cond. 50' adjacent parking lot . . . \$105,000. Phone: 626-7652 LuCLIFF REALTORS, 848-9240.

IDEAL LOCATION FOR DOCTOR in River Forest, Illinois. **HOME FOR SALE:** Red Brick Col., 4 Br., 2 1/2 Bths., Large Lv. & Dn. Rms., new Kitchen, pan. Library, Solarium, paneled Rec. Rm., 3 Fireplaces, 15 closets, Central Air. Lot 70x190. Nr. schools, shopping, transportation. Within 20 minutes to ST. ANNE, WESTLAKE, LOYOLA, GOTTLEIB, and NORTHLAKE HOSPITALS. Low 90's. By appt. only. Phone (312) FO 8-8435.

FOR SALE, LEASE OR RENT (Con't)

REAL ESTATE INVESTMENT OPPORTUNITY for **MEDI-GROUP**. 100 acres in active Northwest Chicagoland suburbs. Top growth area—zoned for multi-family and commercial use. Ideal location for Medical Center. Main road exposure. Priced below the market. Small down payment with interest only payments available on easy terms (great tax deductions). Outstanding capital gain situation! Contact: Ronald Weisner, Weisner Realty, Inc., 2545 Peterson Avenue, Chicago, Illinois 60659 or call: 312-728-6500.

OUTSTANDING PRACTICE AVAILABLE IN SOUTH ST. LOUIS. Stable practice of deceased South St. Louis physician affords excellent professional and financial opportunity. Surgical and general practice with heavy concentration on industrial accounts. Economical and efficient office available with excellent equipment. Space could accommodate partners if desired. Estate will consider either cash sale or installment basis. Call: 314-843-4998 or 314-353-4466.

FOR RENT 4010 W. MADISON STREET—OFFICE SPACE available for Medical Doctors. No need to buy a practice. We have plenty of patients for you. 1-2-3 Room Suites. Immediate Possession. Call: Illinois Property Management Corp., Mr. R. M. Ryan, Agent. 312-243-2727.

FOR RENT: Beautiful suite available in medical center. Nice mid-western city located near Chicago. 1,000 square feet. Ideal for any medical practice. West Side Professional Building. 1795 Grandstand Place, Elgin, Ill. 60120. 312-695-8618.

NEW MEDICAL OFFICES AVAILABLE SOUTHWEST CHICAGO (vicinity 47th & Cicero) to specialize in Welfare Recipients. Contact: Mr. Goldberg, 312-767-4050.

INTERNIST-CARDIOLOGIST! ESTABLISHED PRACTICE AVAILABLE IN CHICAGO, ILLINOIS. Excellent opportunity for one or more doctors. Well equipped modern offices across the street from hospital. Reasonable terms. Contact: B. Robert Gassman, C.P.A. Phone: 312-831-4749 or answer service: phone 312-CR 2-7262.

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A MULTIDISCIPLINE RESEARCH GROUP providing consultation advice and services in the areas of organizational development and evaluation. Evaluational Research Consultants International, P.O. Box 66587, O'Hare International Airport, Chicago, Illinois 60066.

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NOTE:

*Professional qualifications of Paramedical Personnel are subject to review by prospective physician employers.

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284	American National Bank	411	Health Education and Welfare/ <i>National Health</i> <i>Services</i>
267-268	Blue Cross/Blue Shield	270	INTRAV/ <i>South American Adventure</i>
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295	Chicago Title and Trust	269	U.S. Navy/ <i>Navy Medical Corps</i>
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430	Gamma Laboratory	438-439	Classified Advertising
432	Healthways, Inc./ <i>Medical Surgical Supplies</i> <i>and Equipment</i>	435-436	Physician Recruitment

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Illinois Medical Journal

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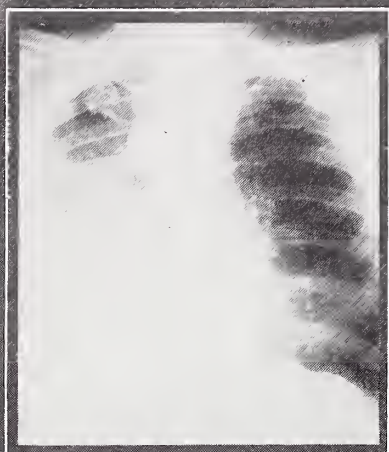
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A Physician's Bill of Rights—see page 465

John E. Bushnell

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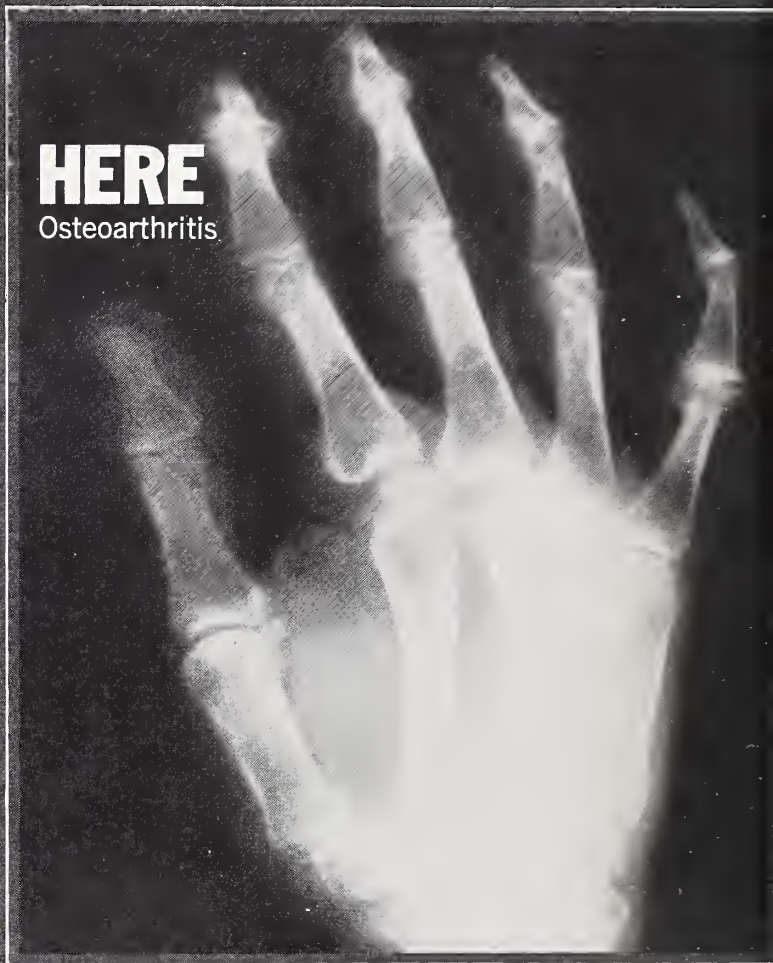
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BLUE SHIELD REPORT





FOR *Illinois Physicians*

MAY WE HAVE YOUR ASSISTANCE?

The Blue Shield Plan of Illinois Medical Service, through the Professional Relations Department, is developing data on our Blue Shield Usual and Customary fee program to aid us in processing your Blue Shield claims accurately and without unnecessary delays.

So that we can be sure the information we have on record is accurate and up-to-date, you may receive the following letter from us after you have filed a claim, asking that you supply us with information on your Usual fee for the professional service to our member, approximate date this fee was established, or if it was not your Usual fee, a description of any complications or unusual medical circumstances involved that influenced the charge reported.

Blue Shield	
233 North Michigan Avenue Chicago, Illinois 60601 312/661-2500	
Patient: Date of Service: Service Rendered: Fee Charged:	
Dear Doctor:	
Thank you for the report of professional services to our member who is covered under our Blue Shield Usual and Customary fee program.	
This claim has been released for payment. However, we need the following information to aid us in processing your future Blue Shield claims accurately and without unnecessary delay.	
1. Is the fee charged in this case your Usual Fee for this service? Yes () No ()	
2. If Yes, please give the approximate date this fee was established.	
3. If No, please describe any complications or unusual medical circumstances involved in this particular case that influenced the charge reported. _____ _____ _____	
4. To enable us to process your future Blue Shield claims accurately and promptly we would appreciate your attaching a listing of your current fees, if they are easily available, for those services most frequently performed by you and the date these fees were established.	
Thank you for your cooperation and assistance.	
Sincerely,  Walter R. Livingston, Assistant Vice-President Professional Relations Department	
_____ Signature of Physician	_____ Date signed
BS-174 9-71	Illinois Medical Service (a Blue Shield Plan)

A request is also made for a listing of your current fees, if they are easily available, for those services most frequently performed by you and the date these fees were established. Your assistance in returning this information to us promptly will be appreciated and help us in the completion of this program.

If you have any questions concerning the letter, please contact your Professional Relations Representative, or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Avenue, Chicago, Illinois 60601.

Thank you for your assistance.

ASK BLUE SHIELD ... ABOUT MEDICARE

Medicare Coverage to Persons Needing Renal Dialysis or Transplant

One of the most significant changes in Medicare protection came with an amendment effective July 1, 1973 covering persons under age 65 who need hemodialysis or renal transplantation and meet the basic requirements for benefits under this new coverage.

Individuals are entitled to coverage under the program if:

(1) The person is either fully or currently insured under Social Security or receiving monthly Social Security benefits;

(2) He or she is the spouse or dependent child of one who meets the insured status or monthly benefit requirement; and

(3) It has been medically determined that the patient has a chronic kidney disease and requires renal dialysis or transplant.

When the insured requirements and medical determinations have been met, eligibility begins on the first day of the third month in which a course of hemodialysis begins. For example, if treatment began May 25, 1973 the patient would have been covered effective August 1, but no benefits would be provided before July 1, 1973 at which time the amendment became effective. Medicare coverage continues through the 12th month after the month in which an individual has a successful transplant or dialysis terminates.

Medicare coverage for persons disabled with a severe kidney impairment is the same as that for the elderly. The benefits, therefore, help pay for hospital and medical costs in addition to those connected with the treatment of the disease.

Hospital insurance protection is provided without payment of a premium, but medical insurance for physicians' services, outpatient services and related medical expenses is provided through payment of the Part B premium of \$6.30 per month.

The types of physicians' services rendered to chronic renal disease patients include: (1) In-patient services for stabilization of renal failure and during hospitalization for a secondary condition; (2) necessary services performed during dialysis other than supervision during a dialysis "run", and (3) follow-up office visits to review patient progress. Basically, physicians' services rendered to a chronic renal disease patient are covered if determined to be reasonable and necessary.

Patients may obtain further information and instructions from medical centers through which they receive dialysis treatment or from which they have obtained dialysis equipment for use in the home, and from their local Social Security office.

SSA Changes in Lab Certifications

The Social Security Administration has made the following changes in the participation of laboratories in the Medicare program:

Approved for Medicare participation:

Flossmoor Commons Medical Laboratory
3235 Vollmer Road
Flossmoor, Illinois 60422
Effective Date: June 22, 1973
Provider Number 14-8261

Omega II Medical Laboratory, Inc.
515 West Ogden
Downers Grove, Illinois 60515
Effective Date: July 31, 1973
Provider Number 14-8255

West Town Medical Laboratory
9651 West Irving Park Road
Schiller Park, Illinois 60176
Effective Date: August 17, 1973
Provider Number 14-8256

Oak Crest Clinical Laboratory
10522 South Cicero Avenue
Oak Lawn, Illinois 60454
Effective Date: August 10, 1973
Provider Number 14-8252

Norsom Medical Reference Laboratory
710 West Higgins Road
Park Ridge, Illinois 60008
Effective Date: August 14, 1973
Provider Number 14-8253

Ridgeland Medical Laboratory
328 Madison Street
Oak Park, Illinois 60302
Effective Date: August 20, 1973
Provider Number 14-8254

Approved the withdrawal from Medicare participation:

Victoria Laboratories, Ltd.
5767 North Milwaukee Avenue
Chicago, Illinois 60646
Effective Date: August 14, 1973
Provider Number 14-8207

Associated Medical Laboratories, Inc.
4753 North Broadway
Chicago, Illinois 60640
Effective Date: October 1, 1973
Provider Number 14-8076

Jeffery Center Clinical Laboratory
200 East 75th Street
Chicago, Illinois 60619
Effective Date: October 1, 1973
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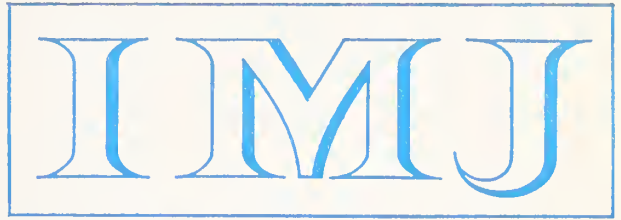
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Illinois Medical Journal

NOVEMBER, 1973

Vol. 144, No. 5

CONTENTS

Special Articles

- 464 Physician's Bill of Rights
Willard C. Scrivner, M.D.
- 493 "Where Have All the Doctors Gone?"
Charles J. Jannings, III, M.D.
- 499 Are You Satisfied With Your CME?
Leonard S. Stein, Ph.D.
-

Clinical Articles

- 473 An Unusual Presacral Tumor
Frederick Weiss, M.D., C. F. Vallejes, M.D. and Eli Tobias, M.D.
- 477 Case Report: Pancreatic Transplantation for Diabetes Mellitus
Frederick K. Merkel, M.D., Will G. Ryan, M.D., Kent Armbruster, M.D., Sandra K. Seim, M.S. and Todd S. Ing, M.D.
- 480 Detection of Breast Cancer—A Review of Cancer Registry from Blessing Hospital, Quincy
Ernst Griep, M.D.
-

Surgical Grand Rounds

- 484 Bronchogenic Cysts
John M. Beal, M.D., Editor
-

Trauma Center

- 487 An Ambulance Strategy for Illinois
David R. Boyd, M.D.C.M., Michal K. McGrady, B.S., Carol E. Anderson, B.A. and Winifred Ann Pizzano, B.A.
-

Medical Legal Review

- 504 The Hospital Practice of Medicine
Donal D. O'Sullivan, M.D., J.D. and Herman Wing, M.D., LL.B.
-

(Contents continued overleaf)

Features

- 464 President's Page
- 502 ISMS Guide to Continuing Medical Education
- 510 View Box
- 512 EKG of the Month
- 513 Editorial
- 514 Clinics For Crippled Children
- 517 Membership Forum
- 520 Pulse of the Doctor's Wife
- 522 Illinois Society, American Association of Medical Assistants
- 523 Physician Recruitment
- 526 Obituaries
- 527 New Pharmaceutical Specialties

(Cover by Jane E. Bushwaller)

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Each Spansule[®] (brand of sustained release capsule) contains 8 mg. of Teldrin[®] (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; and 2.5 mg. of isopropamide, as the iodide.

Knows the public's enemies — nasal congestion, runny nose, sneezing, watery eyes.

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Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

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Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

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Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

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ROCHE announces
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BACTRIMTM

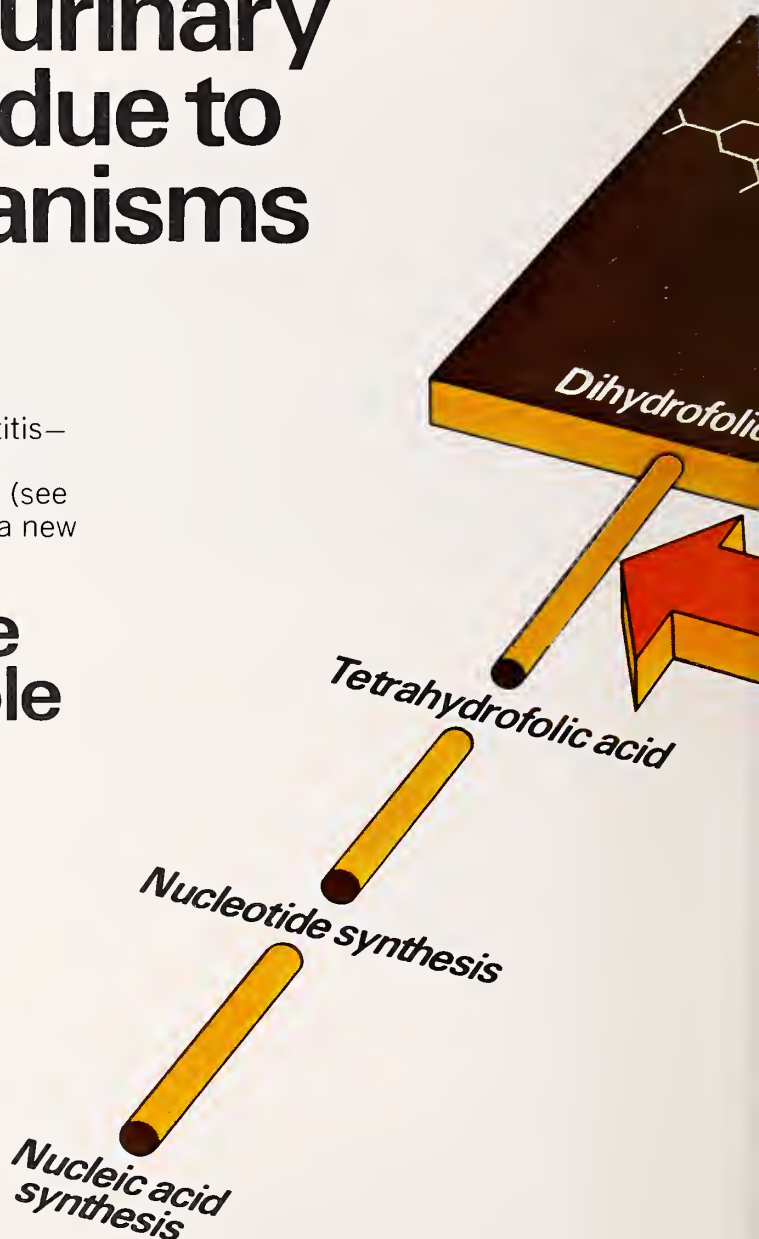
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

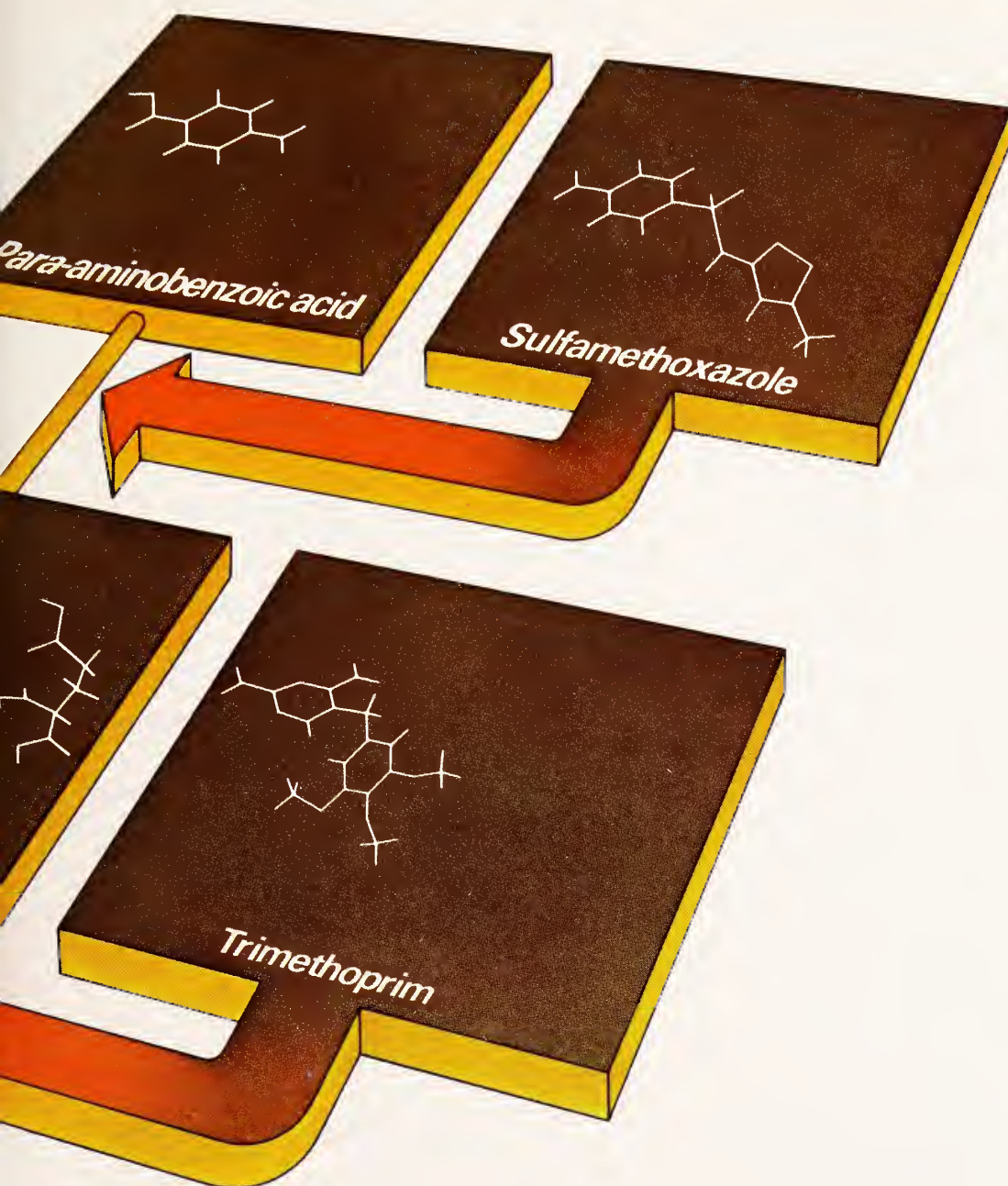
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





new **BACTRIM**^{T.M.}

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

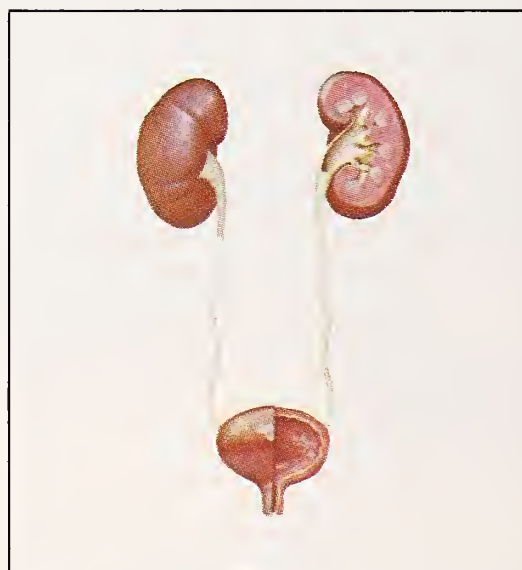
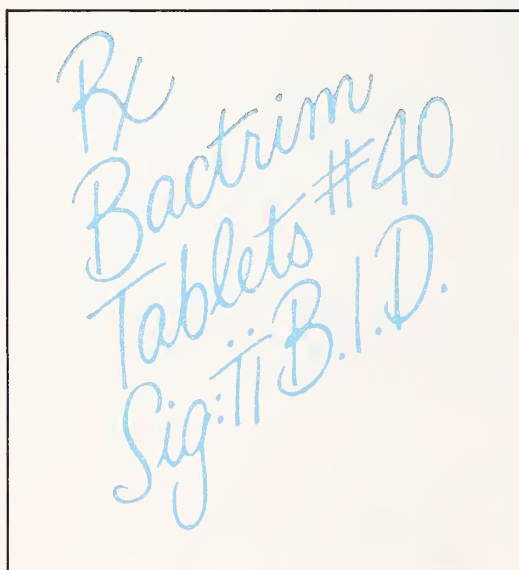
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

[†]4 patients not available for evaluation at day 10.



new **BACTRIM**TM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

In Gonorrhea

Injection **WYCILLIN®**
(sterile procaine penicillin G
suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae*: acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity.

Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistamines appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisypilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by deep intramuscular injection, in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated) — Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae*. Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages.

And destroy another link in the chain of infection.

In Syphilis

Injection

BICILLIN® Long-Acting
(sterile benzathine penicillin G
suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If

allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by deep intramuscular injection in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories • Philadelphia, Pa. 19101



It's time for action to defend the laws and regulations that protect your patients against drug substitution.

**These professional and trade organizations are united
in supporting antisubstitution statutes and regulations:**

The American Academy of Dermatology

The Board of Directors of the
American Academy of Family
Physicians

The Executive Board of the
American Academy of Neurology

The Committee on Drugs of the
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

The Board of Trustees of the
American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Association

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter-professional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

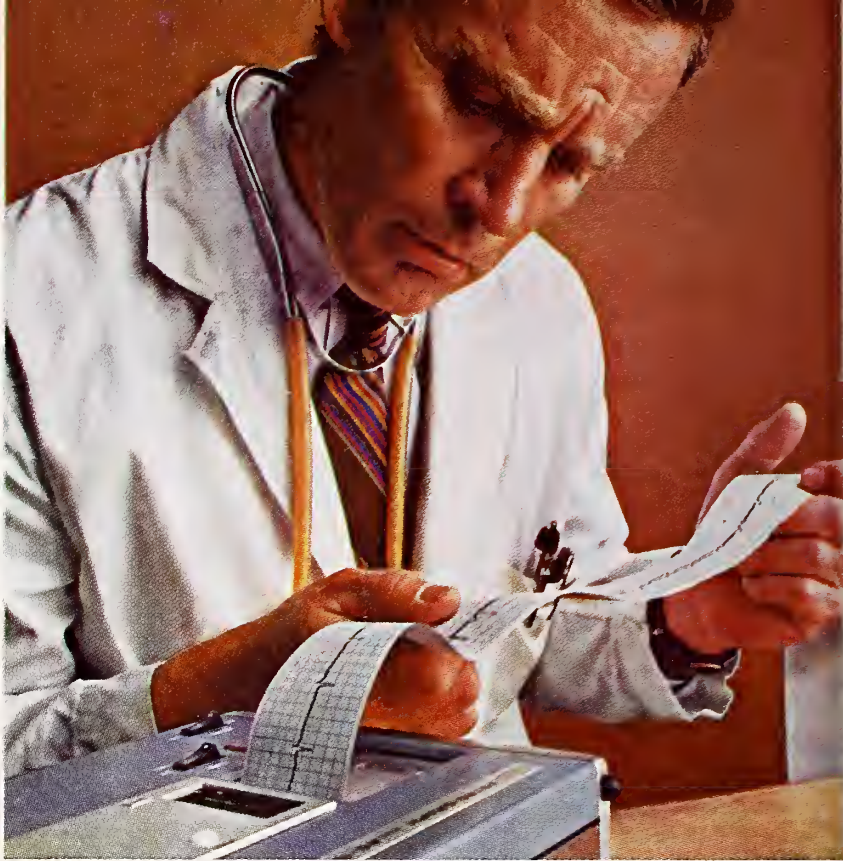
There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005



When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions

organic basis and that reduction of excessive anxiety and emotional overreaction would be medically beneficial.

The benefits of antianxiety therapy

Antianxiety medication, when used to complement counseling and reassurance, should be both effective and comparatively free from undesirable side effects. More than 13 years of extensive clinical experience has demonstrated that Librium (chlordiazepoxide HCl) fulfills these requirements with a high degree of consistency. Because of its wide margin of safety, Librium may generally be administered for extended periods, at the physician's discretion, without diminution of effect or need for increase in dosage. (See summary of prescribing information.) If cardiovascular drugs are necessary, Librium is used concomitantly whenever anxiety is a clinically significant factor. (See Precautions.) Librium should be discontinued when anxiety has been reduced to appropriate levels.

For relief of
excessive anxiety
adjunctive

Librium® 10mg
(chlordiazepoxide HCl)
1 or 2 capsules t.i.d./q.i.d.

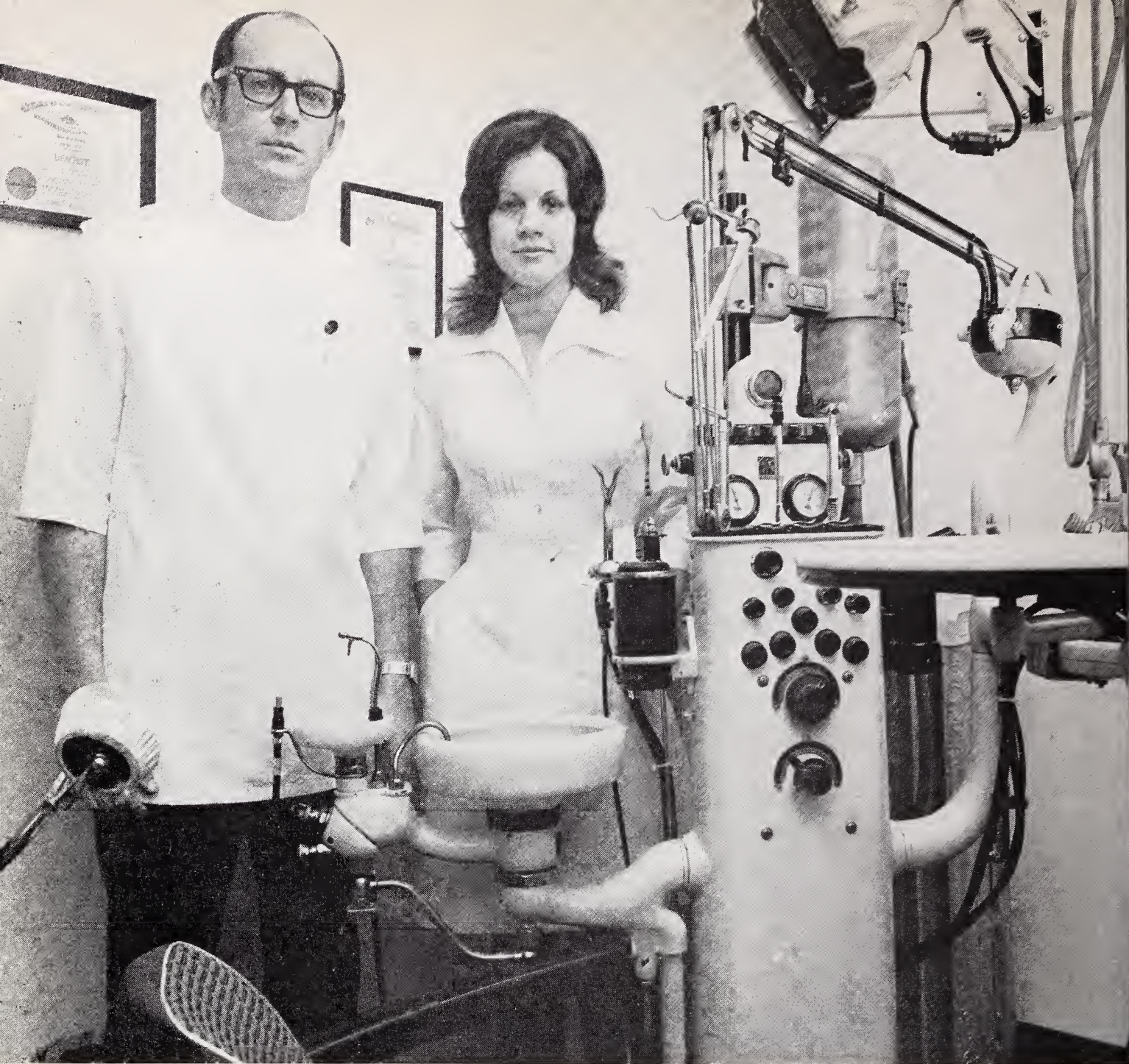


Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



Even a small corporation needs a profit sharing plan.

Maybe you can count the people in your corporation on one jaw. But even if your business isn't big, you can still set up a money-making profit sharing plan. Our *Master Profit Sharing Plan* makes it easy.

Do you know why more and more incorporated professionals use profit sharing? First, it's a tax shelter for your income. You can put up to 15% of payroll in the plan. Second, professional money managers keep your money invested, so your profits produce more profits. Nobody can guarantee what rate of return you'll get. But here are the amounts you could

receive if you put aside just \$1,000 per year for 25 years:

Rate of Return (Compounded Annually)	Total in 25 years
8%	\$73,106
6%	54,865
4%	41,646

When you adopt our Master Profit Sharing Plan nearly two dozen of Chicago's best qualified money managers watch over your investments. They're backed up by thorough economic analysis, market research and eighty five years of profitable history in assets management. We handle all the details too. The paperwork, rec-

ords, government forms and approvals are all taken care of.

It doesn't matter whether your corporation has three employees or 3,000. Your profits could work harder for you and your future in Chicago Title and Trust's Master Profit Sharing Plan. For a free booklet describing this plan, just call Jack Osgood at 332-7700.

**Chicago Title and
Trust Company**

111 West Washington Street, Chicago, Illinois 60602
Member of the Lincoln National family of corporations.



**Your experience has
shown you the benefits
of Lasix[®] (furosemide)
in initial therapy of
cardiac edema.**

Now...

(See prescribing information on last page of this ad.)

consider

LAAS

(FUROSE

in long-term



tablets
40 mg

TM

X MIDE) therapy

-wide range of effectiveness allows you to treat most degrees of cardiac edema.

-dry weight can be reliably and safely maintained by adjusting the dose to fit your patient's needs. With doses exceeding 80 mg /day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

-patient inconvenience is minimal since diuresis is usually complete within six to eight hours.

(See Lasix - [furosemide] prescribing information on last page of this ad.)

LASIX® (FUROSEMIDE)

TABLETS 40 mg

in long-term therapy



WARNING—Lasix® (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities, the drug is contraindicated in women of child-bearing potential.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix, children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients. Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium depleting steroids.

Frequent serum electrolyte, CO₂ and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix.

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion.

In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

When parenteral use of Lasix precedes its oral use, it should be kept in mind that cases of reversible deafness and tinnitus following the injection

of Lasix (furosemide) have been reported. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic dose of 1 to 2 ampuls (20 to 40 mg).

Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose, and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour post-prandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites. It has been reported in the literature that diuretics such as furosemide may enhance the nephrotoxicity of cephaloridine. Therefore, Lasix and cephaloridine should not be administered simultaneously.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue Lasix for one week prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, erythema multiforme, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, light-headedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

DOSAGE AND ADMINISTRATION—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced.

If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). The dose of Lasix may be carefully titrated up to 600 mg per day in those patients with severe clinical edematous states. Higher doses are currently under investigation.

The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg/day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

Hypertension—The usual dose of Lasix is one tablet (40 mg) twice daily both for initiation of therapy and for maintenance. Careful observations for changes in blood pressure must be made when this compound is used with other antihypertensive drugs, especially during initial therapy. The dosage of other agents must be reduced by at least 50 percent as soon as Lasix is added to the regimen to prevent excessive drop in blood pressure. As the blood pressure falls under the potentiating effect of Lasix, a further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary. It is further recommended, if one tablet (40 mg) twice daily does not lead to a clinically satisfactory response, to add other hypotensive agents, e.g., reserpine, rather than to increase the dose of Lasix.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

HOW SUPPLIED—Lasix (furosemide) Tablets are supplied as white, monogrammed, scored tablets of 40 mg in amber bottles of 100 (FSN 6505-062-3336), 500, and Unit Dose 100's (20 strips of 5) (FSN 6505-117-5982). Note: Dispense in dark containers. Exposure to light may cause slight discoloration which, however, does not alter potency.

PRINTED IN U. S. A. 3-73

Start with— and stay with Lasix® (FUROSEMIDE)



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PHARMACEUTICALS, INC.
SOMERVILLE, N.J. 08876

Physicians like the kind of prescriptions we write.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

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Stand Up And Be Counted



During my years in organized medicine, my actions always have been guided by the opinions and concerns of the practicing physician. Interestingly, but not surprisingly, I have found that we are united by a bond of common concern about the forces influencing our profession.

Physicians are beset by increasing demands upon the health care system, increasing health care costs, increasing government and other third-party intervention, and an ever-increasing number of malpractice suits.

But these problems are overridden by another factor which we must recognize: we are losing our influence upon the future of our profession.

We have been robbed of our traditional leadership role in the health care system.

Enthusiastic reformers in and out of government have tried to relegate the practicing physician to a junior role. Politicians have been particularly guilty of assuming health care responsibilities which rightfully belong to doctors. At the same time, officeholders have misled the public with unrealistic promises of universal low-cost medical care. These promises will not come to fruition as easily as some politicians lead the public to believe. But if they do, it will be at the expense of the physician.

Legislative Threat

Let's look at the events of recent months.

During the last session of the General Assembly, one legislator proposed suspension or revocation of a physician's license if he refused to treat Medicare or Medicaid patients.

The proposal was defeated. But why was it introduced? The Department of Public Aid indicated that last year 8,500 of the 9,700 office-based, patient-care physicians in Illinois treated Medicaid recipients. It is quite possible that most of the other 1,200 physicians were located in areas where there are few, if any, Medicaid recipients. No physician should refuse to care for a patient on the basis of his source of payment, but what has happened to the physician's right to choose his patients?

We have treated and will continue to treat Medicaid patients even though we receive less than our usual and customary fees. The Medicaid fee schedule always will be unrealistic. Last January, IDPA appropriated an additional \$5 million for fiscal 1973 to upgrade Medicaid pay-

ments to reflect 1971 charge levels. We encounter similar "unusual" and "uncustomary" fee schedules under the Medicare program.

It appears, however, that our cooperation with these programs isn't enough. The same government which gave us Medicare and Medicaid recently gave us PSRO. It represents further government encroachment into medicine. But if we choose not to cooperate with government in its implementation of PSRO, the alternatives can destroy our profession.

Government, as we have seen, seldom is an ally. And, sadly, those who should be allies are turning against us.

Hospitals are infringing upon our rights by silencing the voices of medical staffs. Influenced by a questionable interpretation of an Illinois Supreme Court decision—which held a private hospital liable for medical staff negligence—some hospitals are unilaterally revising medical staff bylaws and transferring final responsibility for medical care to lay-dominated boards of trustees. In effect, this places physicians in a subservient position and gives the board responsibility for monitoring the day-to-day quality of care rendered by the staff.

Our profession also has suffered at the hands of insurance carriers who have established—without consulting physicians—what they call "usual and customary fee profiles."

Aid for Plaintiffs

Last April, one carrier offered legal assistance to patients in actions initiated by physicians seeking to recover charges exceeding group insurance benefits. The company inferred that physicians' prevailing charges, which were higher than the carrier's fee profiles, were unreasonable.

The most vocal critics of the medical profession point to rising health care costs. We can't deny health care costs are rising, but what costs aren't? However, our critics seem to ignore the fact that the expensive tools, techniques and training of contemporary medicine are providing an unparalleled standard of care.

These same critics also ignore the prevailing malpractice climate in Illinois and throughout the country. Physician's fees reflect the practice of positive defensive medicine. We often are forced to order tests and X-rays that could—if needed—build the basis for a solid defense in court. There also is the element of negative de-

fensive medicine; physicians may shy away from treating patients with ailments or maladies that fall into high risk groups. This costs the patient in terms of both quality and availability of medical care.

Third-party interference has gone far enough. We must draw a line beyond which we will not tolerate further encroachment upon the traditional doctor-patient relationship.

It is time for me, as your president, and for you, as practicing physicians whom I represent,

to stand up to those who would tell us how to care for our patients.

I have faith in my colleagues . . . I believe in my profession . . . and I refuse to give another inch to those who so freely compromise our rights.

Thus, I am issuing my ultimatums: I offer to you a "Physician's Bill of Rights".*

Willard C. Scrivner M.D.

Physician's Bill of Rights

Whereas, the President of the Illinois State Medical Society, Willard C. Scrivner, M.D. out of his concern over the increasing encroachment of third parties and others into the physician-patient relationship, has written a Physician's Bill of Rights; and

Whereas, this Bill of Rights has the approval and endorsement of the Board of Trustees of the Illinois State Medical Society, therefore be it

Resolved, That the American Medical Association adopt the following to be a Physician's Bill of Rights:

1. We support the goal of making available high quality health care to all people. However, we vigorously oppose employing any means to attain this goal which would compromise the patient's freedom of choice or the physician's right to care for his patients in the manner which his training, experience and judgment dictate to be most effective.
2. We believe physicians, as professionals, should be allowed to use their knowledge and training for the benefit of all people without government interference and harassment or relegation to the status of government employees.
3. We reject as a matter of principle the arbitrary development of compensation guidelines for physicians' services by government and insurance companies without prior participation and approval.
4. We reject as a matter of principle all formulas for compensation for physician's services not based upon usual, customary and reasonable fee concepts.
5. As part of their responsibility to the policyholder and to the public, insurance companies and others providing coverage for medical care should specify in clear and understandable language all benefit limitations.
6. We reject as a matter of principle insurance companies and others providing medical service coverage implying to policyholders that physicians' charges are excessive.
7. If an insurance company questions a physician's charges, its medical director or another qualified professional should attempt to resolve the problem by contacting the physician. If they are unable to reach an agreement, the company should present its complaint to the local medical society's peer review committee.
8. We reject discrimination in physicians' compensation for similar services based solely upon geographic location. We contend that this discourages physicians from establishing practices in rural and other areas already severely affected by a maldistribution of the physician population.
9. Governing boards and hospital authorities will not be permitted to unilaterally develop bylaws governing the conduct of medical staffs without the participation and formal approval of the staffs involved. Such action will result in prompt counteraction, beginning with an appeal to the Joint Commission on Hospital Accreditation, and including legal or other steps appropriate to the situation.
10. Only physicians licensed to practice medicine in all its branches shall be authorized to admit patients or discharge them from hospitals and other health facilities.
11. Complaints by patients regarding the quality and manner of care rendered by a physician should be made in writing, notarized, and submitted to the physician's local county medical society. Patients should be informed that it may be necessary to confront the accused during review proceedings.
12. Unauthorized substitution of prescribed items will be viewed by physicians as the illegal practice of medicine and will be met with counteraction, legal or otherwise as the situation warrants; and be it further

Resolved, that this Bill of Rights becomes effective upon adoption, and implementation will, if necessary, include court action.

*This "Bill of Rights" will be presented as a resolution for action by the AMA House of Delegates which meets December 1-5 in Anaheim, Calif.



A VERY SOUND BARRIER



For patients who can't or won't use the "pill" or an IUD

While no contraceptive is one hundred percent effective, the Ortho All-Flex Diaphragm and Ortho-Gynol Contraceptive Jelly, together, act as a very effective barrier to conception and is a method that is rarely contraindicated.

Ortho All-Flex is designed to provide comfort and reliability and to meet the highest esthetic standards of the most discriminating women.

Ortho All-Flex Diaphragms are made of high quality, long-lasting latex. They won't discolor when used with Ortho-Gynol Contraceptive Jelly or Ortho-Creme* since these contain no phenylmercuric acetates. No introducer is needed; the unique spring-within-a-spring construction forms a perfect arc wherever compressed.

Consider the advantages of prescribing the Ortho All-Flex Diaphragm and Ortho-Gynol when you and your patient decide on the diaphragm and jelly method of conception control.



If you would like a professional fitting-ring set and fitting-procedure brochure, please contact your Ortho representative.

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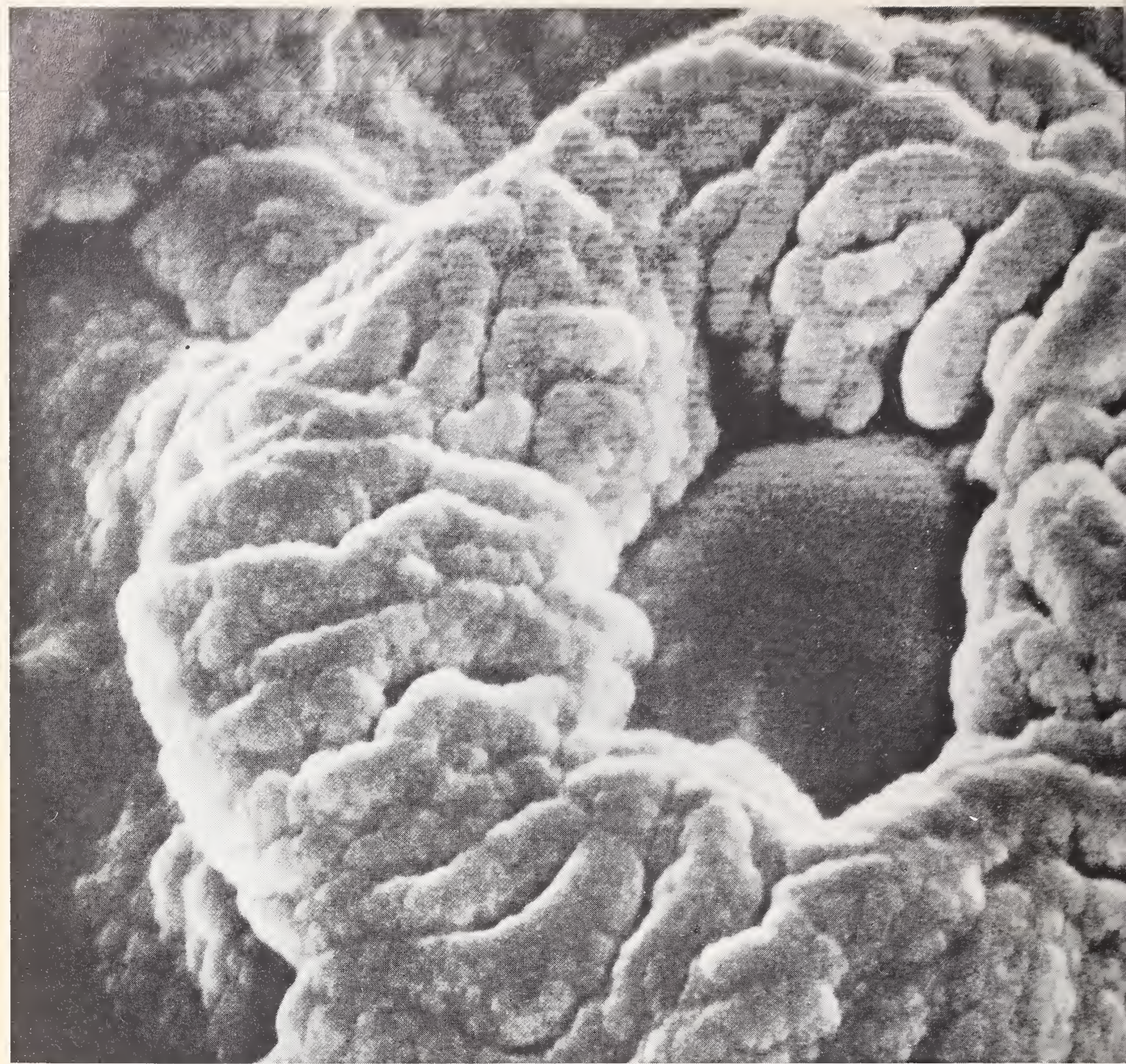
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This Scanning Electron Micrograph (7000 \times) is the first 3-dimensional view of a cell in an ulcerated duodenum. The center is completely denuded, surrounded by fairly well-preserved microvilli. This SEM photomicrograph was taken from a scientific exhibit which won the Hull Award as the "best exhibit on original research or instruction on a medical subject" at the A.M.A. Clinical Convention, November 26-29, 1972, in Cincinnati, Ohio.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been



The Tireless Man

whose duodenal ulcer needs a rest

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Up to 8 capsules daily in divided doses

For optimal response, dosage should be adjusted to your patient's requirements—1 or 2 capsules, 3 or 4 times daily. Rx: Librax #35 for initial evaluation of patient response to therapy. Rx: Librax #100 for follow-up therapy—this prescription for 2 or 3 weeks' medication can help maintain patient gains while permitting less frequent visits.

For the anxiety-linked symptoms of duodenal ulcer adjunctive

Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating

breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males
edema

aggravation of migraine headaches
change in body weight (increase, decrease)
headache

allergic rash

hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

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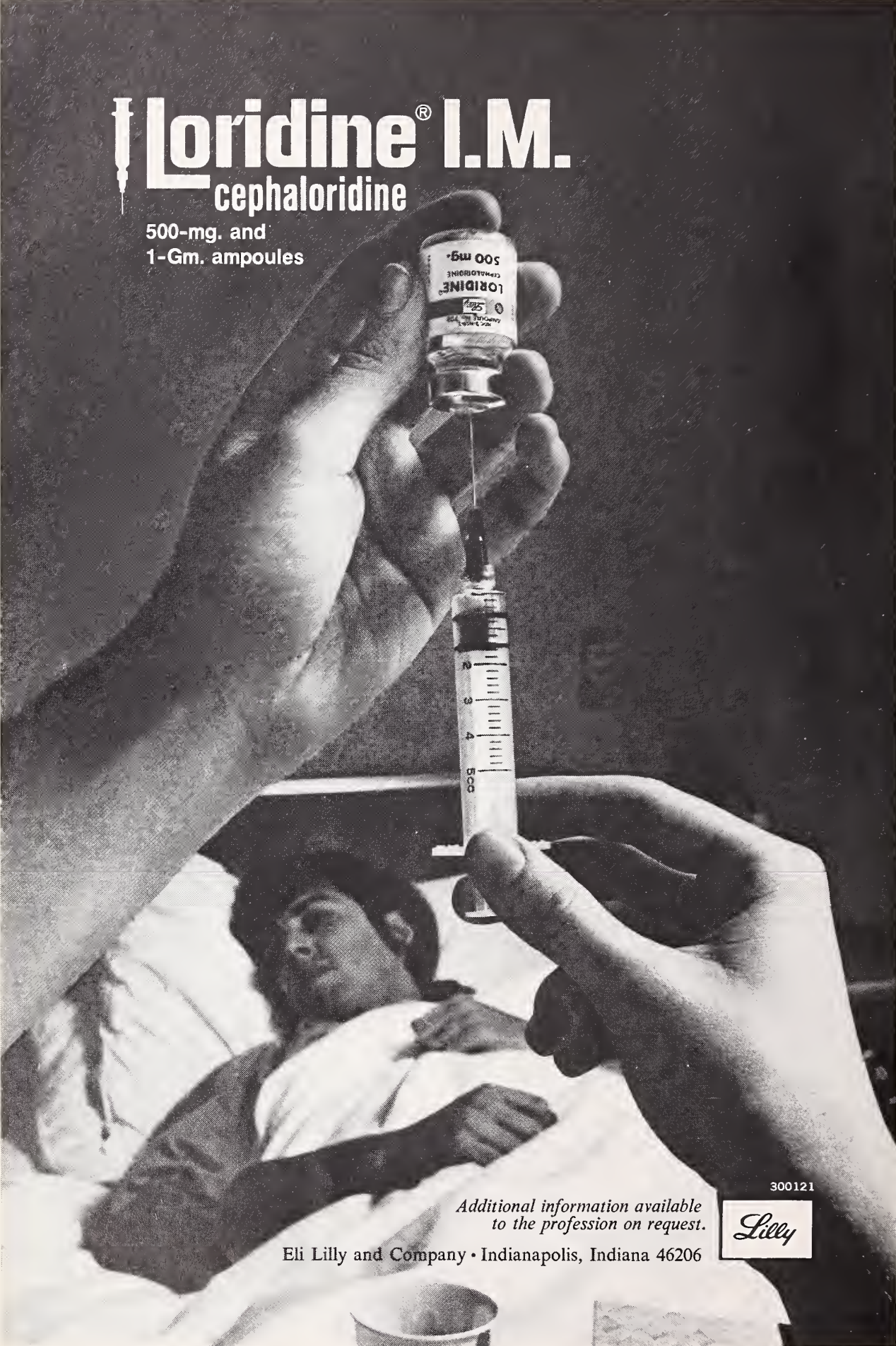
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Illinois Medical Journal

Vol. 144, No. 5, November, 1973

An Unusual Presacral Tumor

By FREDERICK WEISS, M.D., C. F. VALLEJOS, M.D. AND ELI TOBIAS, M.D./HARVEY

The purpose of this article is to alert the physician to the possible existence of a presacral mass that is detectable rectally, vaginally, or by abdominal examination and is rarely reported.

The case presented is the 60th recorded in a review of over a century of medical literature. The first case presented was done in 1837, as reported in the *Lancet* by "a distinguished surgeon," anonymous at his request."¹ T. A. Emmet reported a case in 1871, with a mortality. As reviewed by Vogel,¹ it was "a rare form of spina bifida, the sac pressing into the abdominal cavity and of a size to present features in common with an ovarian cyst." An extensive review was done by Haddad,² at which time he presented a résumé of 53 cases.

This article presents diagnostic signs and surgical approach discussion. The authors believe that with the increased awareness of the symptomatology and the components of the physical examination, along with the ancillary modalities

for diagnosis, it will make tumors of this nature more frequently recognized.

Case Report

A white male, 27 years of age, was admitted to the hospital with a chronic complaint of low back pain. He described radiation of pain to both legs with a "pins and needles" sensation, aggravated by movement of the trunk. Occasionally symptoms of pain developed in the low back with movements of the head and neck. Strain and stress, as sometimes produced by defecation, in addition to rectal distress, would produce headache, and the patient described a progressive constipation with episodes of appearance of bright red blood in the stool.

Medical and Surgical History:

The patient's general medical history, with review of systems, was unenlightening as to the present condition. Surgically, he had been operated on four years earlier for the treatment of "chronic low back pain." At that time, a spinal fusion was performed. The surgical record was reviewed and it was noted that there was no abnormality of intervertebral disc described at operation. There was also no recorded description of rectal examination by the orthopedic surgeon in attendance. Likewise, there was no

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Weiss

ELI TOBIAS, M.D., a neurosurgeon, is an Assistant Professor of Neurosurgery at the University of Illinois College of Medicine. Dr. Tobias is a member of the Congress of Neurological Surgeons and the American Board of Neurological Surgeons. C. F. VALLEJOS, M.D., a general surgeon, is a member of the American Thoracic Society, American College of Chest Surgeons and the Illinois State Medical Society.

myelogram done prior to his surgical procedure.

Clinical Examination:

Abdominal examination was negative for masses or abnormality. By digital rectal examination, the prostate was found to be normal in size, consistency and position. In the posterior aspect of the rectum, in the region of the sacral hollow, a firm, somewhat compressible mass was palpable and appeared to be submucosal. The location was essentially in the midline with symmetrical, bilateral extension—total width approximately 6 cms. The examining finger could not reach the cephalad portion of the mass. Sigmoidoscopic examination was unsuccessful, revealing inter-external hemorrhoids and a bulging mass in the posterior aspect of the ampulla. It was not deemed safe to attempt to advance the instrument because of the protrusion and distortion of the ampulla. The visible mucous membrane was normal in appearance.

Neurological examination was negative, with reflexes of normal quality bilaterally. There was no demonstrable sensory or motor impairment. Examination of the back showed impaired anterior flexion and rotation. There was no evident spasm of the paravertebral musculature. A well-healed midline incision was present, extending from L-1 to S-1.

Laboratory Examination:

Laboratory tests were within normal limits with the exception of blood in the stool .

Radiographic Examination:

Colon studies revealed anterior displacement of the rectum due to a large mass anterior to the sacrum and coccyx. The mass contained areas of varying densities but no calcifications.

Intravenous pyelography demonstrated mild bilateral pyelectasia; the ureters and urinary bladder were normal.

X-ray of the low back, incorporating the lumbosacral area and the coccyx, showed partial fusion of the fourth and fifth lumbar vertebrae. The coccyx was described as being rudimentary and anomalous in formation. The inferior surface of the right wing of the sacrum showed an anomalous protrusion (Figure 1).

Differential Diagnosis:

On the basis of location of the mass, it was evident that a wide range of diagnostic pos-

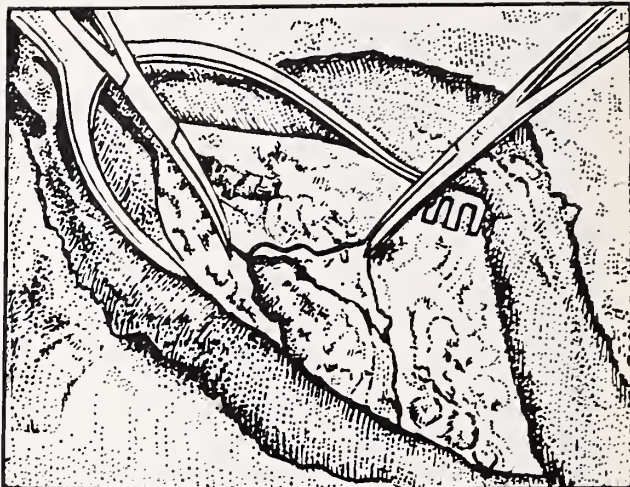


Figure 1. Sac of meningocele exposed by posterior approach.

sibilities existed. In the differential diagnosis the following entities were considered: dermoid cyst, teratoma, primary malignancy, metastatic disease, lymphomatous disease, and tumors of neurogenic origin, including meningocele.

Consideration was then given to the potential course of treatment and whether we should do a transrectal needle biopsy. However, after thorough review, a consultation with a neurosurgeon was secured and it was agreed that the only rational mode of therapy must be a surgical exploration via a posterior approach. This would entail exposure of the coccyx, which was described on X-ray as being anomalous and rudimentary. This approach should then permit us to be directly over the mass for easy accessibility.

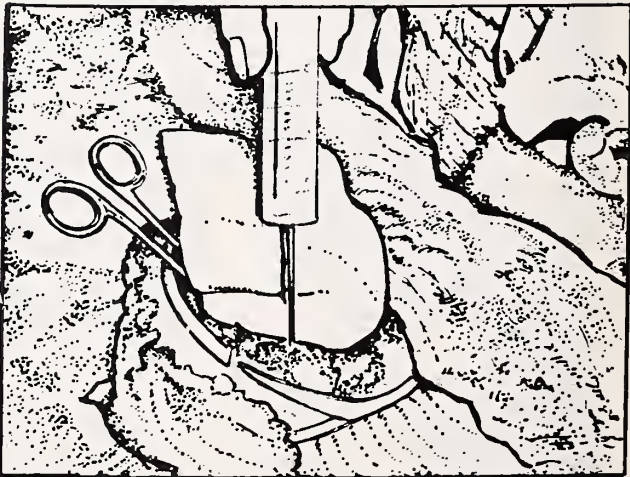


Figure 2. Aspiration of clear fluid from the meningocele.

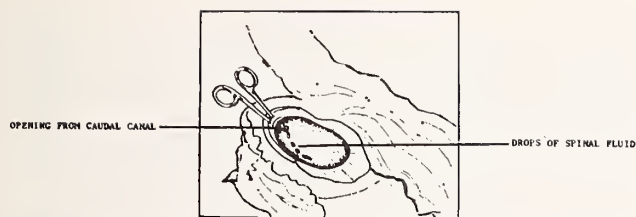


Figure 3. Schematic design of interior of meningocele.

Surgical Procedure:

After induction of general anesthesia per endotracheal route, the patient was turned to the prone position. The sacral area, buttocks and pararectal regions were carefully shaved and suitably prepared and draped. A midline incision was made from the inferior pole of the sacrum to a point 5 cms. above the rectum. Skin, subcutaneous tissue, fascia and periosteum were divided, and the coccyx exposed. A window was cut in the coccyx with Kerrison bone cutting forceps, revealing a large tense bluish domed cystic mass (Figure 1). A 19-gauge needle was inserted carefully into the sac and clear colorless fluid was aspirated (Figure 2). The fluid was sent to the laboratory for analysis, although the clinical impression was "cerebrospinal fluid." The cyst sac was then incised, drained of fluid and the sac collapsed. The posterior wall of the sac was excised and, internally within the cyst, a small ostium was located at the superior pole of the cavity and clear cerebrospinal fluid could be seen trickling in intermittently (Figure 3). This opening was sutured with a circumferential 3-0 Mersilene suture. The suture effectively stopped any further fluid drainage. Soft tissue closure was then accomplished and performed in layers with interrupted 3-0 Mersilene sutures for the skin. Pressure dressings were applied. A digital examination, after the operation was completed, revealed that the previously palpated mass was no longer evident.

The post surgical course was uneventful and the patient was discharged from the hospital on the seventh post surgical day. At the time of discharge, the patient was free of pain and reported daily reduction of sensation of tingling in the extremities, as originally described.

Laboratory Findings:

The fluid taken from the cyst sac was identified as cerebrospinal fluid. The pathologist described the tissue specimen as compatible with "men-

ingocele," describing the presence of sympathetic ganglion cells, neural tissue and epithelial cells.

The findings of an anterior meningocele, surgically, then prompted us to review the literature, which revealed that the anterior meningocele is a much rarer disease entity than the occurrence of the posterior meningocele. The latter occurs predominantly in infants and in children, and frequently occurs with related spina bifida. The anterior meningocele seemingly occurs nearly eight times more frequently in the female than in the male. It must be considered that these statistics might be quite inaccurate and may be related to the fact that females are examined pelvically and rectally much more frequently than males. Also, females are subjected to surgical exploration of these regions much more frequently, and this may account for the data as previously presented. It is of interest to note that the diagnosis was clear, in this case, only after surgical unroofing of the coccyx was performed and the bulging sac exposed.

Pathology:

The pathology of an anterior meningocele is said to be due to "partial agenesis of the sacrum, in contrast to the failure of the formed posterior arches to fuse as in posterior meningocele."³ The sac is a protrusion of the meninges of the sacrum. Usually the sac has a narrow neck and contains cerebrospinal fluid. The wall may contain neural elements, glial tissue or even portions of the cauda equina.

Discussion

Presenting symptomatology, in this case, relates in general to problems arising from pres-

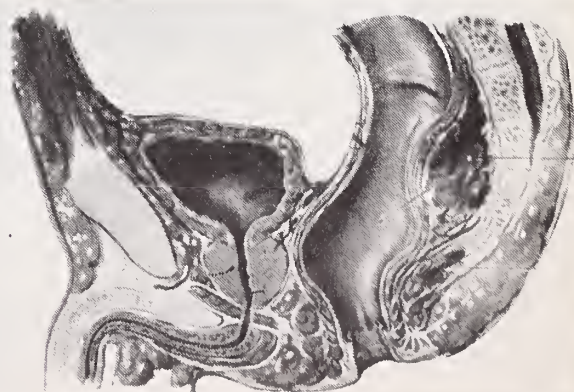


Figure 4. Displacement of the rectum.

Possible Complications

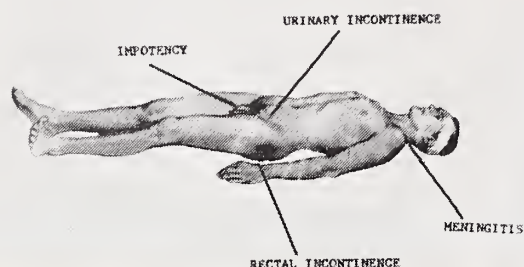


Figure 5

sure on contiguous organs such as the rectum or the bladder. The neurological symptoms of the type described herein may be present, as well as those secondary to an increase in intracranial pressure.²

Retention may occur in the urinary system.³ Disturbances in bowel habits may result in symptoms ranging from episodic constipation to distal large bowel obstruction (Figure 5). In the female, dysmenorrhea and dystocia have been described as presenting signs. Encroachment on the rami of the lumbosacral nerve segments may produce peripheral paresthesias.⁶

Headaches may occur if communication develops between the meningocele and the subarachnoid space. These headaches usually present themselves while the patient is crouching or straining at stool. Relief occurs when the patient is placed in the supine position.

The diagnosis rests on two important points—direct palpation of the mass and on the radiological finding of a “scimitar” sacrum. What was described on the X-rays as being an anomalous and rudimentary coccyx has long been described as a “scimitar” sacrum.

Awareness on the part of the radiologist and the physician of this finding of an anomalous sacrum, presenting a “scimitar sign,”^{2,5} should almost be diagnostic of an anterior meningocele. However, consideration must be given to myelography as a contrast radiographic technique and, if one is fortunate, the dye will enter the meningocele sac and completely delineate it.

Treatment

Treatment, historically, has ranged from “skillful neglect”² to radical surgical procedures. The approach has been transabdominal as well as from the posterior aspect, as described in this

DIAGNOSIS

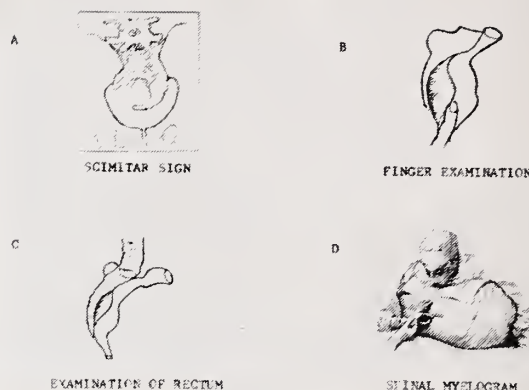


Figure 6

case. Cases have been described where the meningocele produced large bowel obstruction and preliminary diversionary colostomy was necessary.

In the handling of the sac surgically, it has been variously totally extirpated, marsupialized, unroofed, and variations inbetween. It is extremely important, regardless of choice of procedure, to ligate the stalk opening to avoid neurological complications, such as ascending infection, bleeding and loss of cerebrospinal fluid.⁷

In general, the conservative surgical approach of unroofing the sac and ligating the stalk appears to be the method of choice.⁶ Wide resection must certainly be approached with a great deal of care because of the possibilities of secondary urinary incontinence and, in this case, impotency in the male.⁸

We add to this that a diagnostic transrectal needling procedure would be foolhardy and could initiate a meningitis, as originally described by Emmet¹ in 1871. Posterior aspiration, or needle biopsy would have been possible in this case.

Summary

We have presented a case report after review of the literature concerning the presacral, or anterior meningocele. In over 100 years, only 59 cases have been reported in literature, and this is the 60th as of the date presented in May, 1968. The authors suggest that this tumor may be much more common than these numbers indicate. The fact that six times, or more, as many meningoceles in this area have been found
(Continued on page 518)

Case Report:

Pancreatic Transplantation For Diabetes Mellitus

BY FREDERICK K. MERKEL, M.D., WILL G. RYAN, M.D., KENT ARMBRUSTER, M.D.,
SANDRA SEIM, M.S., AND TODD S. ING, M.D./CHICAGO

Despite the use of exogenous insulin, the vasculopathy of Juvenile Diabetes remains a problem without a satisfactory solution. Diabetic angiopathy remains the third leading cause of blindness in the United States today. Nearly 20% of deaths attributable to diabetes are a result of diabetic glomerulosclerosis.¹ Clearly, new approaches are necessary. Pancreatic allotransplantation is now being employed at Rush-Presbyterian-St. Luke's Medical Center, Chicago, for patients with severe diabetic retinopathy or nephropathy in an attempt to more satisfactorily correct the metabolic disorder. Only by clinical trials can it be determined whether or not correction of the metabolic disorder by this method can prevent these vascular complications.

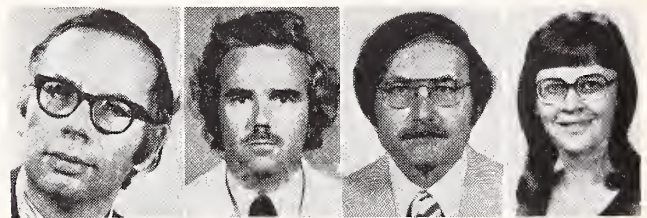
Case Report

W. L., the recipient of the *first* human pancreatic transplant performed at Rush-Presbyterian-St. Luke's Medical Center, is a 36-year-old caucasian male. He developed childhood onset diabetes at age 15 and remained free of complications while being treated with regular insulin until age 19 when he suffered his first and only episode of diabetic coma. Subsequently, he was placed on long acting insulin, with which he suffered several insulin reactions.

Seven years ago he sustained an acute retinal hemorrhage, retinal detachment, and subsequent blindness in the right eye. Multiple photocoagulation treatments for hemorrhages of the left fundus resulted in visual acuity at present of 20/200 in the left eye. He was admitted to Rush-Presbyterian-St. Luke's Medical Center for evaluation for pancreatic transplant in February, 1973, and found to be well developed, well nourished, but with obvious reduction in visual acuity. The blood pressure was 120/80 and he had a pulse rate of 84 per minute. Physical examination was unremarkable. He exhibited mild slowing of peripheral nerve conduction presumably secondary to his diabetes.

Laboratory Data: The hematocrit was 38%, blood urea nitrogen 20 mg%, creatinine 1.1

Supported in part by the Endocrinology Research Fund, the American Diabetes Association, and funds from the Section of Transplantation, Rush-Presbyterian-St. Luke's Medical Center.



Merkel

Ryan

Armbruster

Seim

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KENT ARMBRUSTER, M.D., Villa Park, is an instructor in the Department of Medicine at Rush-Presbyterian-St. Luke's Medical Center. Dr. Armbruster graduated from the University of Illinois College of Medicine and served under a Renal Fellowship at RPSL Hospital.

SANDRA K. SEIM, M.S., Oak Park, is a medical technologist in the Section of Transplantation at Rush-Presbyterian-St. Luke's Medical Center. She received her M.S. degree at Northwestern University.

TODD S. ING, M.D., is a Nephrologist at Rush-Presbyterian-St. Luke's Medical Center.

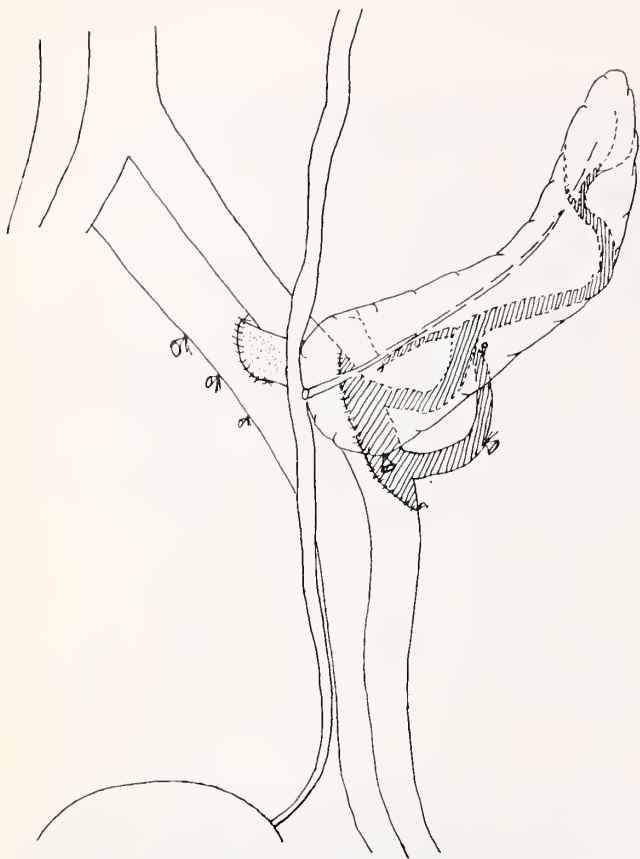


Fig. 1. The technique employed for the pancreas transplant. Note: The portal vein of the graft is sutured end to side to the recipient's left iliac vein; a patch of donor aorta bearing the celiac and superior mesenteric arteries was inserted into a similar defect in the recipient iliac artery; and the donor pancreatic duct was sutured end to side to the recipient ureter as shown.

mg%, and creatinine clearance 97 ml/min. The urinalysis revealed hyaline and granular casts as well as 3+ proteinuria and glycosuria. The IVP and voiding cystourethrogram were normal.

On May 18, 1973, a ten year old child with cerebral death became available for organ donation at Rush-Presbyterian-St. Luke's Medical Center. Cardiovascular stabilization was effected by administration of albumin and IV fluids and diuresis was produced with furosemide.

The donor's kidneys were removed individually and preserved by means of pulsatile perfusion until suitable recipients were chosen for renal transplantation. Meanwhile, the pancreas was dissection using a "no touch" technique. However, the duodenum and head of the donor pancreas was discarded and only the body and tail transplanted.

When the donor dissection was nearly complete, the recipient was anesthetized and the left groin vessels were prepared to receive the graft through a small incision similar to that used for hernia operations. The recipient's own pancreas

was left untouched. When all was ready, the donor's pancreas was excised, perfused with an intracellular type solution, and sutured in place in the left iliac fossa. (Fig. 1) The donor portal vein was anastomosed end to side to the recipient left iliac vein and a patch of the donor aorta bearing the celiac and superior mesenteric arteries was inserted into a similar sized defect made in the left iliac artery near the ligated and divided hypogastric artery. An arteriogram carried out shortly after transplant illustrates the vascular anatomy. (Fig. 2) The pancreatic duct was anastomosed to the nearby ureter end to side using a micro suture technique and a silastic catheter was placed across the anastomosis and into the bladder as a stent. (Fig. 3) The wound was closed over suction catheter drainage.

The patient tolerated the operation very well and within a few days he required no insulin, maintaining fasting blood sugars in the range of 100-150 mg%. There was no glycosuria and he ate a regular diet. All this was in spite of receiving 100 mg of Prednisone daily. The urine amylase quickly became elevated and remained high until rejection destroyed the transplant function. (Fig. 4)

Several days following rejection, the wound was explored and a biopsy of the necrotic pan-



Fig. 2. An arteriogram showing the arterial connections of the graft. The clips outline the substance of the transplant indicating its size. The recipient hypogastric artery on that side has been ligated.

creas was taken. The wound was left open to close by granulation and secondary intention. Insulin therapy was instituted at doses greater than prior to transplant in order to compensate for the steroids used to combat rejection. Nevertheless, his postoperative course was smooth and uneventful. The wound healed rapidly and the patient is now home eagerly awaiting another chance at pancreatic transplantation.

Discussion

To date, only 32 pancreatic transplants are recorded at the American College of Surgeons/National Institutes of Health Organ Transplant Registry.² This is to be compared with the nearly 15,000 kidney transplants reported to this Registry. Truly, pancreas transplantation is an embryonic field that needs exploration. The method used here differs from techniques previously reported by this author^{3,4} and is modified from a technique recently reported by Gliedman.⁵

The other techniques previously used include pancreaticoduodenal grafts and pancreatic duct ligated transplants.

The theoretical advantages of our new technique include freedom from the complications of the duodenum such as infection and hemorrhage,



Fig. 3. An intravenous pyelogram illustrates the relationship between the pancreatic transplant and the host's left ureter. The central clip adjacent to the ureter marks the site of the pancreatic duct-ureter anastomosis.

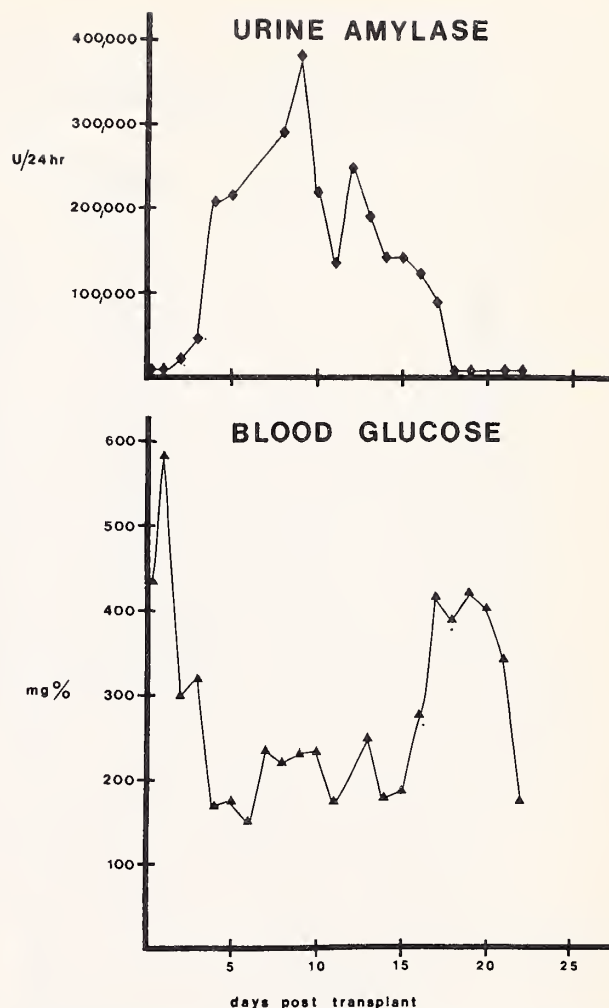


Fig. 4. The effect of the transplant on blood glucose and urine amylase is shown. By three days, the graft controlled blood sugar without need for insulin. Rejection was signaled by a rise in blood sugar to 400 mg%. The return to normal of the blood sugar values at 21 days was a result of exogenous insulin therapy.

The urine amylase indicated satisfactory function of the graft until 15 days with cessation of function at 18 days. These values paralleled the blood sugars.

a characteristic of intestinal rejection, and fibrosis with loss of endocrine function, a problem in the long term duct ligated gland.

Although the donor operation requires skill, gentleness and patience, the recipient procedure is quite straightforward and simple to do. It is well tolerated by the patient and recovery is astonishingly rapid. Furthermore, failure of the graft was tolerated easily with little apparent injury to the patient.

Most of the recipients previously reported have had transplants of both the pancreas and the kidney. Such patients exhibited the degenerative changes characteristic of both long standing juvenile diabetes mellitus and chronic uremia. Despite their dreadful pre-operative condition, a number of the patients have survived for periods

(Continued on page 519)

Detection of Breast Cancer

A Review of Cancer Registry From Blessing Hospital, Quincy

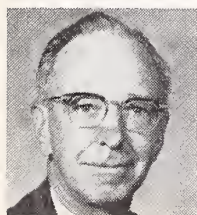
BY ERNST A. GRIEP, M.D./TAMPA, FLA

In view of the increasing interest in the detection of breast cancer at its earliest inception, with the hope that this would help reduce mortality, the cancer registry of Blessing Hospital, Quincy, was screened as to experience over six years. The factors that make this screening particularly important are: 1. The area served by this hospital represents a very stable, non-transient population. 2. The doctors examining and referring tumors of the breast and the surgeons operating tumors of the breast are almost identical during this six year period. 3. Medical service is readily available in this area. There is no social economic bar to early medical consultation by the patient. 4. The laboratory facilities, surgical facilities, X-ray facilities as well as pathologist and radiologists at the reporting hospital were the same during the period reported. 5. During this period of time, and prior to it, there has been an active educational campaign on breast cancer conducted by the local unit of the cancer society. 6. Quite adequate records are available for both clinical and pathological review for the purposes of this review.

Method

This review consisted of 153 cases which were recorded on the tumor registry of proven cases of breast cancer. The records of each of these cases were critically reviewed by the reporting physician. After reviewing these histories and physicals, a total of 132 were selected for evaluation in this survey. The 21 omitted were because of:

1. Insufficient documentation as to time of onset and reporting to physician.
2. Scirrhous carcinoma in the elderly, senile patient.
3. Cases referred from out of this area for cobalt therapy.
4. Known cases of fibrocystic disease which underwent change to carcinoma.
5. Cases referred for treatment of metastatic lesions.



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Who Discovers the Breast Cancer

The first fact that I wish to determine is who discovered the breast cancer, the physician or the patient? In view of the fact that the educational effort of the cancer society had been very active in this area, most women had been informed of the importance of self-examination of the breast and had seen the picture shown by the cancer society. The results of determination of who discovered the breast cancer is graphically recorded in Chart 1. As noted in 1965, 100% of the breast cancers were discovered by the patient while in 1970, 85% were discovered by the patient and 15% were discovered by the physician. However, over the six year period studied, 93% were discovered by the patient, 7% by the physician.

Delay in Seeking Medical Evaluation

Since the patient determines the vast majority of breast tumors, the interval of time was evaluated between when the patient noted this and when she presented herself for medical evaluation. There seems to be no correlation between the early figure at which the patient presented herself for examination at an average time of

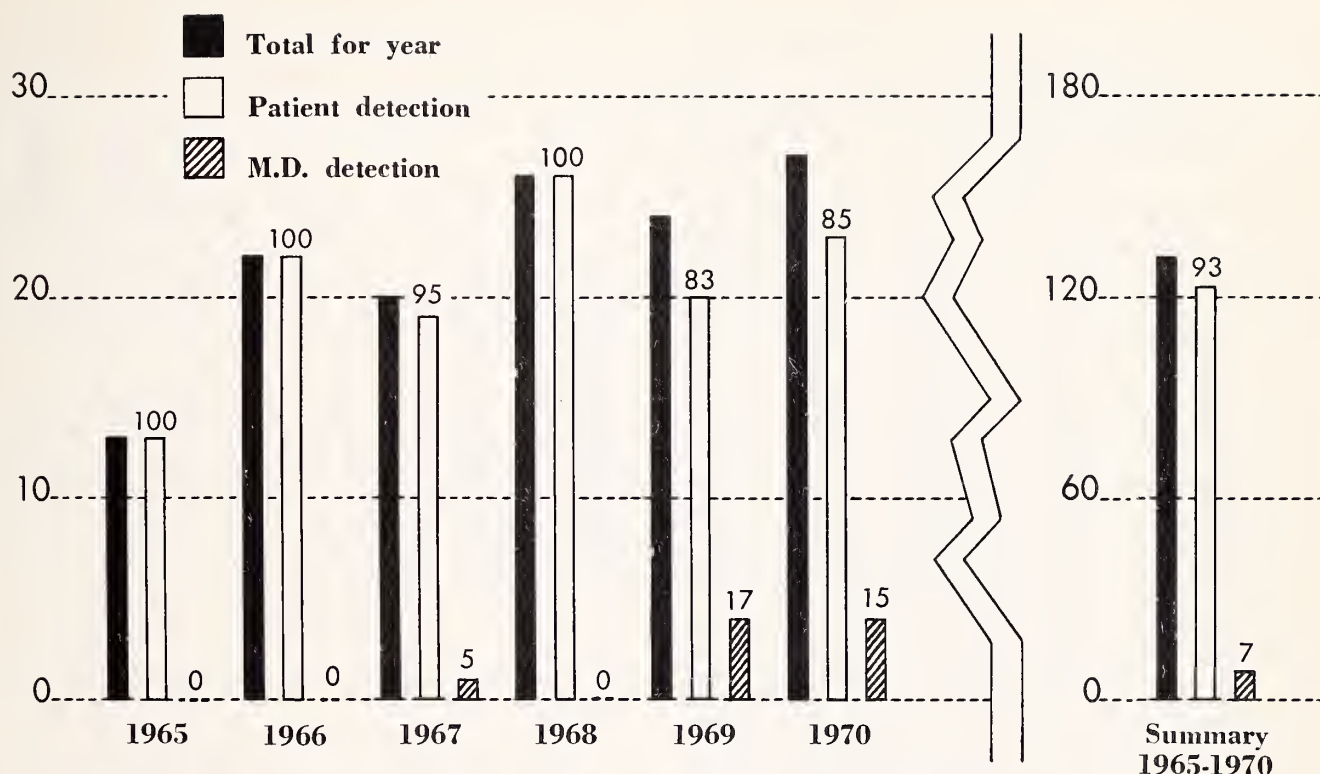


Chart 1. Detection of Carcinoma in a breast by patient or M.D. with percentage.

seven weeks. In 1965, at which time 100% of the proven breast tumors were discovered by the patient, there was an interval of ten weeks before the patient presented herself for medical evaluation. The average interval over the six year period from the time that the patient discovered the lump in the breast until it was medically evaluated was eight weeks. Cases were processed by the physician within one week after the tumor was brought to their attention. In the series reported by Melmed, M. R. Robbins and F. W. Foote, Jr., the average time of delay in seeking treatment was 5.6 months. The physiological variables in patient delay have been studied by Hammerschlag, Fischer, DeCrosse and Kaplan who concluded that the more assured the patient was both in regard to her body and to her environment the greater would be the delay.

Age of Patient:

In view of the fact that we are dealing with a stable population area, the next question is whether the age of the patient varied to any great degree as to the average age at which the tumor was found and as to whether this involved the younger age group. The question of the younger age group is important since this group would be using the progestational drugs

and would be reporting for annual examinations including a Papanicolaou vaginal and breast examination as part of the supervision of their therapy. Comparing the first year of 1965, the average age was 62 years, in 1970 it was 63 years and the average for the six years studied was 62 years. The youngest patient in this age group was 36 years old and the oldest patient was 91. It would appear from this that there is no particular change in the incidence in age or that the more frequent examination on an annual basis has changed the incidence in the younger age group.

Physician Aptitude:

The next factor, the physician's aptitude to the discovery of breast cancer, was evaluated by two means: first, in the patients in this series it was determined from their medical records

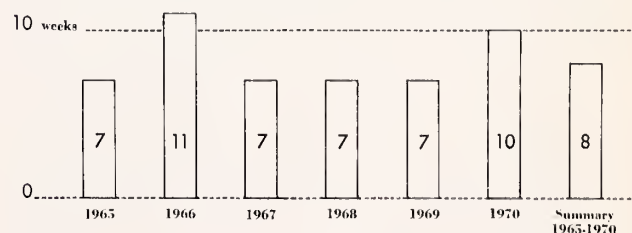


Chart 2. Interval in weeks between discovery and seeing M.D.

if they had been hospitalized within one year before the discovery of the tumor. Office visits were not checked since these mostly involved an anatomically localized complaint. It was found that in 1965 two patients had been hospitalized within a year before the discovery of the tumor and in 1970 three patients had been hospitalized within a year. The total number of patients hospitalized within a year prior to the discovery of the tumor over a 10 year period was ten. The second factor used was the advent of mammography in 1962 with facilities for the mammography available both at the hospital and on out-patient facilities with adequate trained technicians and radiologists. However, it was found that no mammography was done either in the hospital, or as an out-patient on a proven cancer patient until 1969, at which time one patient had mammography. In 1970 there were five patients who had mammography. Therefore, over the total six years, there were six patients who had mammography. In none of these cases did mammography contribute to the diagnosis, since these tumors were clinically palpable. (See Chart 4)

Stage of Present Tumor

With the high discovery rate still with the patient and with the interval between patient discovery and medical evaluation the same, an evaluation of the state of tumor should remain also approximately stable. Chart 5 breaks down the proven cases included in this study as to being 1 and 2, 3 and 4. It is here that there may be some improvement noted, even though the interval of seeking medical consultation is basically unchanged. In 1965, there were 47% of stage 1 and 2 which in 1970 reads 70%. The average of stage 1 and 2 for the six years was 64%. Stage 3 was 30% in 1965 and 14.5% in 1970, with an average of the six years of 27%. Stage 4 with 23% in 1965 and 14.5% in 1970 with an average of the six years of 9%. It is noted that the stage of tumors found at this hospital compares favorable with the statistics of twelve reporting hospitals as reported by

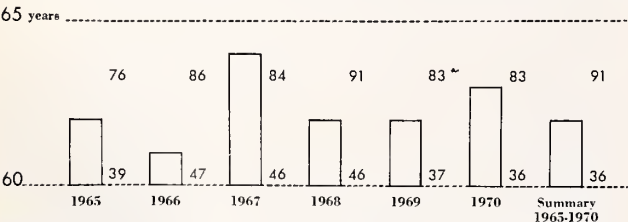


Chart 3. Average age of patient (youngest and oldest indicated by numerals).

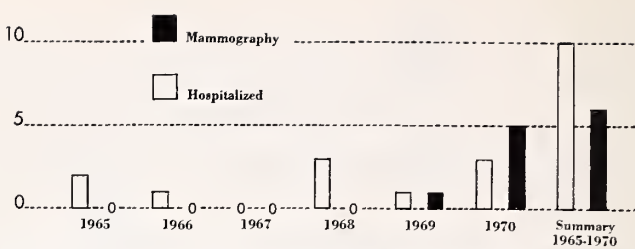


Chart 4. Patient hospitalized within one year before discovery of tumor. Mammography done.

Seidman. Since we have demonstrated a 93% discovery rate of breast tumor by the patient and an average delay of eight weeks in seeking medical evaluation over the six year period studied, the stage of the proven tumor should reflect a stable percentage figure.

Conclusions

The following conclusions can be reached from this study.

1. The patient is the most important factor in the discovery of breast cancer, and the stressing of self-examination of the breast is of extreme importance.
2. There should be much more emphasis placed on the patient promptly seeking medical evaluation of the tumor of the breast which she has discovered.
3. While the age group seems to be that of the post menopause, the use of the indoctrination and instruction of the younger age group for self-examination of the breast should be an extremely important factor. The doctor could carry this on during the time that he is seeing the pre-menopausal patient, perhaps on an annual basis as I suggested, for the evaluation of progestational drugs. It would appear the idea of surveying patients at a long interval of one year with mammography would be questionable in reducing the incidence of breast cancer.

Summary

Presented here is a summary of 132 proven cases of breast cancer with a discussion of the discovery by the patient or the physician; the interval before the patient seeks medical evaluation; the average age of the patient; whether or not the patient has been hospitalized within a year; whether or not mammography was done, and the stage of the breast tumor in the proven case. Basically there has been very little advance in the early diagnosis of breast cancer as shown

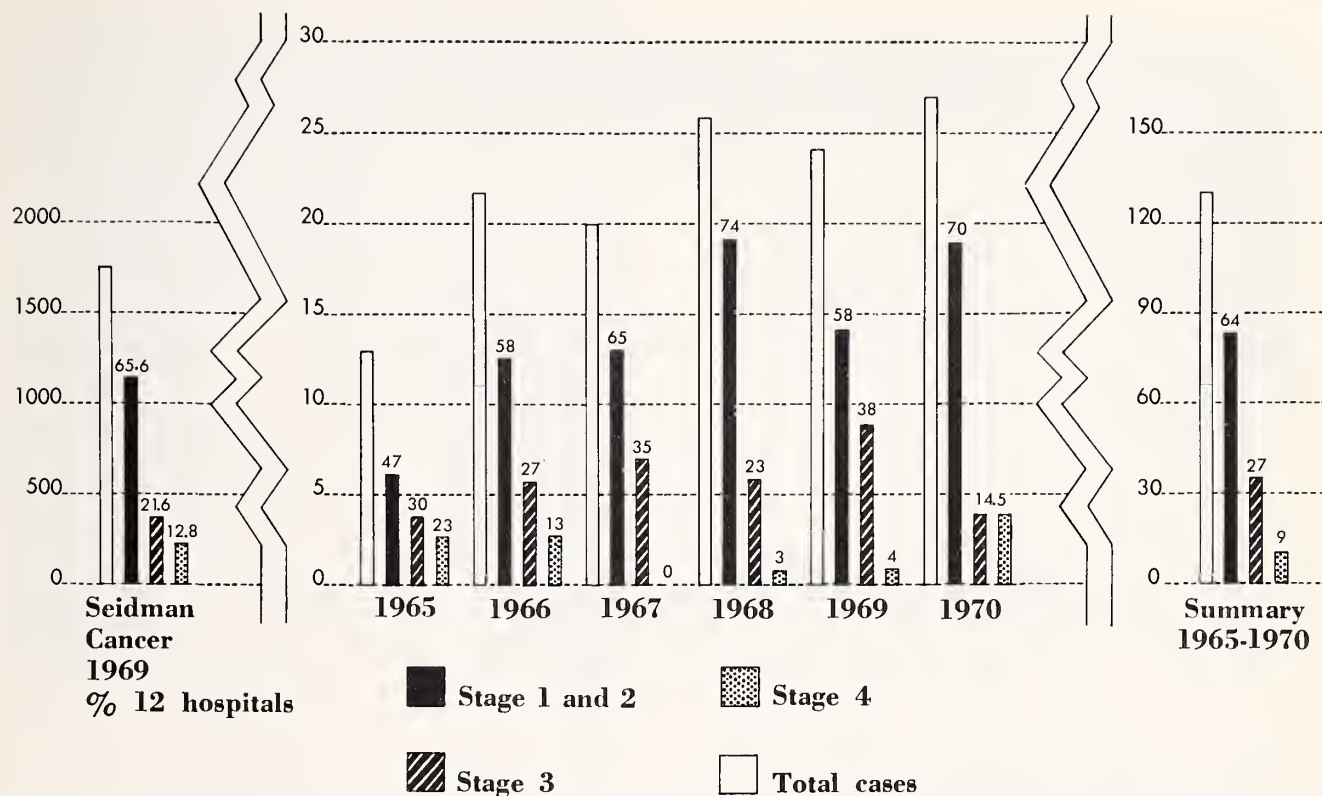


Chart 5. Stage of tumor with percentage.

by this study. With present means of diagnosis it is important to impress upon the patient the importance of self-examination of the breast and to seek medical evaluation early after detection of a breast tumor.

Acknowledgement

Credit is given the administration of Blessing Hospital, Quincy, for the medical records and the tumor registry which assisted in assembling the case records and con-

tributed to the investigation and preparation of the statistics.

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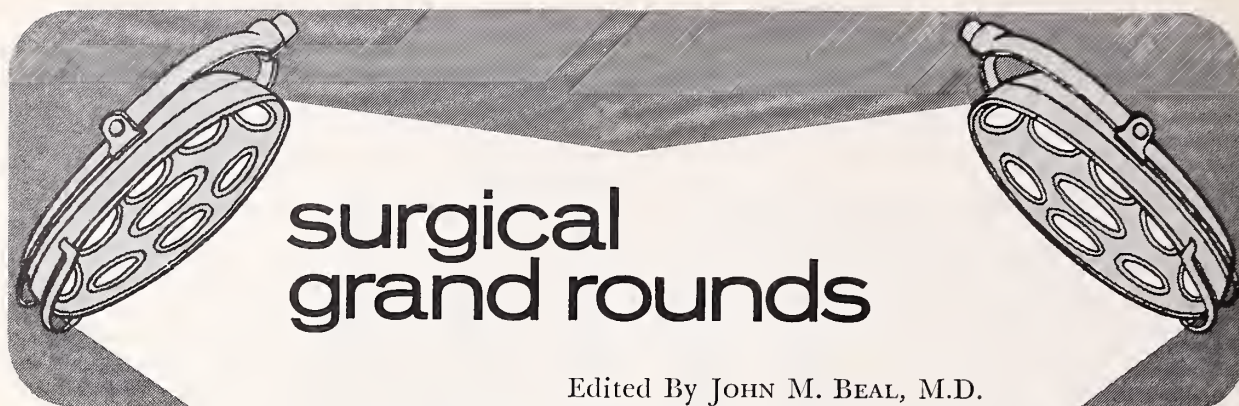
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Physicians and Hospitals

It seems quite redundant, but apparently it is necessary, to call attention to the obvious fact that hospitals cannot function without physicians. Yet no provision is being made for their active involvement in the organizational and authoritative structure of the hospitals. . . . The Lay Board just cannot properly evaluate and select the medical staff; each staff member must be judged by his peers. Only physicians can judge qualifications of the medical men, by and through the Medical Board. To do otherwise would often substitute nepotism for the present rigid review pattern. This could only increase the suits against the hospitals.

The situation is further complicated by the growing policy of having lay community repre-

sentation on the Board of Trustees. What is going to be the relationship of this community representation to the Board of Trustees? Is it not appropriate to request that the noncontributing members of the Board of Trustees and the members of the community and the consumer patient representatives, all of whom obviously cannot give medical care personally nor have knowledge of medicine and medical care, have their deliberations tempered by input from physicians who actually are charged with the real nitty-gritty of giving this care? (Alfred A. Angrist.: (EDITORIAL) "The Developing Confrontation Between Hospitals and Physicians." *New York State Jl. of Medicine* (May 1) 1973, pgs. 1054-1055).



Bronchogenic Cyst

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 13, 1973.

Dr. Robert McClellan: A 42-year-old white male machine operator had enjoyed good health until he was struck in the chest September, 1972. Four days later he developed anterior mid-chest pain without radiation, diaphoresis, shortness of breath or nausea, which lasted for about 10 minutes. These pains increased in severity in October and were pleuritic in nature. He was admitted to a hospital with a diagnosis of suspected coronary insufficiency; however, the electrocardiogram was normal. He was discharged but the chest pain recurred with exertion; he was admitted to the Veterans Administration Research Hospital. He did not complain of shortness of breath, dependent edema, sputum production or orthopnea. He had smoked one and a half packs of cigarettes since age of 18. A history of heart disease, pulmonary disease or allergies was not obtained. Family history and review of systems were non-contributory.

Physical examination: The patient was a well-developed, well-nourished 42-year-old white man not in acute distress but appearing anxious. Lungs were clear and were without wheezes,

ronchi or rales. Heart had normal sinus rhythm without murmurs. Abdomen was unremarkable. Blood pressure 100/55, pulse 70. Laboratory studies at the time of admission: Hemoglobin 14, hematocrit 42.9%, SMA¹⁸ within normal limits, white blood cell count 10,900, and urinalysis was within normal limits. Electrocardiogram was interpreted as normal. A chest X-ray was done.

Dr. Harold Matthies: On the chest radiographs (Figure 1), there is a smooth, round, homogeneous mass in the visceral compartment of the mediastinum which on tomographic studies again show a smooth, homogenous, round well-circumscribed, 8 to 10 cm ovoid mass. (Figure 2) This most probably represents a bronchogenic cyst arising from the region of the carina where most of these cysts originate. The lesion displaces the esophagus to the left which is a usual finding in bronchogenic cysts. An angiocardigram was done and excluded a cardiovascular lesion. Other possibilities include gastroenteric cyst, leiomyoma of the esophageal wall, mediastinal lipoma and mediastinal lymphadenopathy.

Dr. Robert McClellan: Due to the questionable



Figure 1. Chest films demonstrate a homogeneous mass in the visceral compartment of the mediastinum.

shift of the esophagus, esophagoscopy was performed which was within normal limits. Angiocardiography was also performed and the mass was not associated with the heart or aorta. A lung scan, aortogram and pulmonary function studies were within normal limits. Acid fast bacilli was not found in the sputum and intermediate PPD was negative. A right thoracotomy was performed on March 5.

Dr. Larry Wikholm: As Dr. McClellan mentioned, the procedure was performed through a right thoracotomy since this affords the best approach to the subcarinal area. The lesion was found to be a cystic structure in the visceral compartment of the mediastinum located below the tracheal bifurcation. The cyst was mobilized from below upward and it came up quite easily. The cyst appeared to be more densely attached in the area of the tracheal bifurcation but no true vascular pedicle was present. The cyst was relatively thin-walled and was sort of a dumbbell in shape. Upon opening the cyst a rather thick material of yellowish color was present.

Dr. Joseph Sherrick: The wall of the cyst was composed of smooth muscle and contained a few mucous glands, but no cartilage. The cyst was lined by pseudostratified columnar epithelium which showed distinct parallel rows of cilia. (Figure 3) These are the characteristic features of respiratory epithelium. According to Dr. Shields recent text, this is an enterogenous cyst of bronchogenic or bronchial type, one of the more

common mediastinal cysts of adults.

Dr. Larry Wikholm: The term bronchogenic cyst is used to describe this congenital malformation which occurs when a nest of cells become separated from the developing laryngotracheal groove. Since this structure is derived from the foregut, the term enterogenous cyst is used. These cysts are almost always in close association with either the main stem bronchus, the carina, the trachea and only occasionally, the esophagus. These are true cysts in that they have an epithelial lining and they have a muscular wall. At times smooth muscle, elastic tissue, cartilage and occasionally lymphoid tissue are found in the wall. These cysts are usually unilocular, as was the case in our patient, and they contain either a clear odorless material or, on occasion, the fluid may be colored slightly. Some of these cysts may contain gastric or GI tract mucosa. Occasionally, cysts derived from the esophagus will be lined with squamous epithelium. Clinically, these cysts occur in all ages and in both sexes. In adults, the cysts most often are asymptomatic. Thus, they are discovered on routine roentgenograms of the chest X-ray. When symptomatic there may be cough, fever, and sputum production. With a development of an opening between the cyst and the tracheobronchial tree, sputum production is exaggerated by different positions



Figure 2. Tomographic studies outline an 8 x 10 cm. well circumscribed mass, consistent with a bronchogenic cyst.

which would dependently drain the cyst. Hemoptysis has been reported and occasionally, with large cysts, bronchial obstruction and distal infection of the tracheobronchial tree with secondary abscess development has occurred; the roentgenographic findings would be of an air fluid level.

When these cysts occur in children, they often produce symptoms whether or not there is a tracheobronchial communication. When they occur in the first year of life, because of the small size of the airways and the easy compressibility of the tracheobronchial tree, severe respiratory distress may be produced. Occasionally this compression may result in distal infection and obstruction. **Excision is the treatment of choice for non-infected as well as infected cysts. Removal of the asymptomatic lesion is justified for two reasons: (1) to establish a positive tissue diagnosis; and (2) to prevent a secondary bronchial communication.** Malignant degeneration has been reported in one patient but whether or not this was actually true is not known; certainly there is no justification for removal of the lesion on this basis. The dissection is usually easy when there has not been pre-existent inflammation; however, if there is inflammation, the dissection is usually much more difficult.

Dr. Thomas Shields: The enterogenous cysts are almost always unilocular and occur in the visceral compartment. They comprise approximately 11% of mediastinal lesions in adults and 24% in children. In a series of 40 of these cysts, all except five were associated with the trachea or esophagus. Two thirds of these were located in the upper half of the mediastinum and were associated most often with the trachea or the tracheal bifurcation; the remainder were in the lower portion of the mediastinum and were associated with the esophagus.

Almost all of these cysts are asymptomatic in adults, whereas in younger children and infants most are symptomatic. In the latter patients, the symptoms arise as the result of tracheobronchial obstruction. Frequently, severe respiratory distress is noted, and marked dyspnea and cyanosis are often present. Hyperinflation, atelectasis, or infection of either lung occurs. The cyst can be identified only infrequently on routine roentgenographic study of the chest in the symptomatic infant.

When ectopic gastric mucosa is present, ulceration and pain may occur; there may be erosion into an adjacent structure with subsequent development of massive hemorrhage. Hemoptysis may

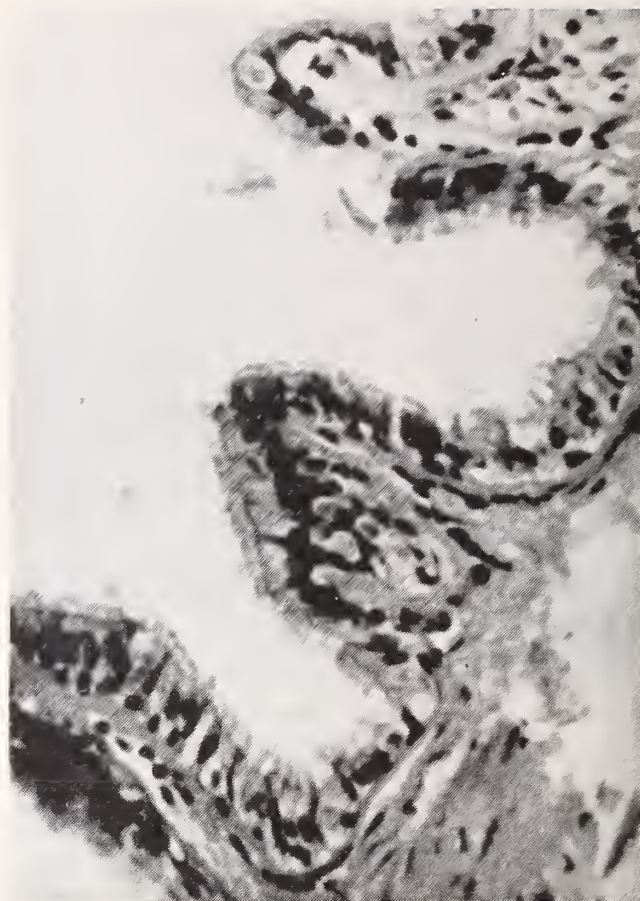


Figure 3. The cyst was found to be lined with ciliated respiratory epithelium.

also occur due to peptic bronchitis.

Early and prompt recognition of the cyst is imperative in the symptomatic infant. If untreated all such patients will die.

The prognosis with removal of these cysts in infants and children, as well as in adults, is excellent.

Dr. John Beal: Dr. Wikholm mentioned that some of these do get infected, does that imply that they do have a communication with the trachea? Or do they get infected without having communication with the trachea?

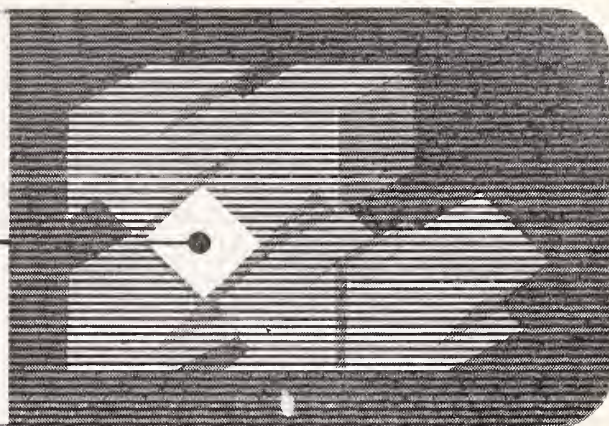
Dr. Thomas Shields: I think that in the past these became infected via the blood stream and only then would it invade and erode into the bronchial tree; this rarely occurs anymore. The last thing I wish to mention is the operative approach. **Any lesion in the region of the carina is best approached from the right side regardless of whether it projects to the right or the left.** ◀

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Trauma Center

DAVID R. BOYD, M.D.C.M., Editor



An Ambulance Strategy For Illinois*

BY DAVID R. BOYD, M.D.C.M., MICHAL K. MCGRADY, B.S.,
CAROL E. ANDERSON, B.A., AND WINIFRED ANN PIZZANO, B.A.

In Illinois, the most glaring missing link in the development of a total response sequence of adequate emergency medical services is that of transportation. The ambulance problem, while not unique to Illinois, is one that this state has an excellent chance of solving. The basic success of the trauma network and the further development of this concept into a program of total emergency medical services makes the resolution of the transportation problem one which can be undertaken and accomplished in a systematic and effective manner.^{1,2}

A significant number of lives can be saved by the provision of adequately sized and designed ambulances with the necessary equipment and properly trained personnel. Under the guidance of a physician-directed medical communications system, they will direct the patient to the most suitable hospital for each critical emergency.

In many areas of Illinois, ambulance services are substandard or essentially non-existent. To correct this health deficiency and to complement and complete the Trauma and Total Emergency Medical Service Program of Illinois, an ambulance strategy has been developed. This strategy is a framework for ambulance service implementation by physicians, hospital administrators, medical providers, health planning groups, and emergency medical services councils.² This strategy has been conceptualized and designed to: (1) build on existing medical resources; (2) consider the population density in need of ambulance

services; (3) integrate highways, roads and access points for ambulance service response; and (4) account for all highway-related accidents and deaths. Also incorporated into the strategy is a notation of special emergency medical problems relevant to any specific community. The strategy involves three types of communities: Chicago and surrounding suburban areas, downstate metropolitan cities (population over 50,000), and, in much greater detail, downstate rural areas. The strategy has defined 176 rural Ambulance Services Districts for downstate Illinois.



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A Change in Public Expectations

Before any improvement in ambulance services can be initiated, the public in each community, whether it be a metropolitan area or a small rural town, must decide that these improvements are, in fact, necessary and desirable. This decision is one which they themselves must make and support. Medical improvements, like other social changes, cannot be dictated and can only be developed with a change in public awareness and attitudes. Once accepted, however, the community's demand for a change and improvement is the key to future progress.

In many parts of the state, ambulance services are totally lacking or are generally inadequate. This is paralleled by a lack of public awareness of how bad things are. Other communities may have resolved to accept what they have ("This is better than nothing") because the level of comparison is so low that new solutions to the ambulance problems are not even considered. Only in those communities where ambulance services are recognized as "shoddy" or "inadequate" or "too expensive" does the consideration of the problem and a desire to change things really come into focus.

Presently in Illinois, an increasing number of communities of all sizes are evaluating this problem and are developing practical solutions for improved ambulance services, as the "mini crises" due to loss of mortician or private services affects their locale. These communities are building a much more adequate ambulance system than was previously available by utilizing federal, state, and local resources³ and assistance.

Chicago and Suburban Areas

In the city of Chicago and surrounding suburban towns, the widest spectrum of ambulance services exists and includes Police squadrols, Chicago Fire Department and other fire department ambulances, and private ambulance services.

An important strategy for the Chicago and suburban area must include: (1) a mission re-orientation for the Police squadrol; (2) a further expansion and upgrading of the Fire Department services, as recommended for Chicago by the Gibson report;⁴ (3) central dispatch and two-way voice control of medical care, triage, and guidance during transport; (4) involvement with Areawide Emergency Medical Service Planning to support the hospital categorization efforts now being implemented statewide; (5) cooperative trade agreements with definition of service areas for primary response

and mutual backup assistance; and (6) municipality (and area) ordinances to protect the interests of those ambulance operators who comply with community standards and to allow better (non-competitive) ambulance operations.

Downstate Metropolitan Districts

Downstate metropolitan districts represent cities such as Peoria, Springfield, Champaign-Urbana, and Danville, with populations between 50,000 and 200,000. These communities have ambulance service problems that are due primarily to the absence of organization and coordination of existing ambulance and rescue operations. A major problem that exists in these communities stems from the lack of cooperation between conflicting ambulance services. Considerable community pressure and awareness has, in many areas, stimulated a great interest in upgrading ambulances, equipment, and personnel to federal and state standards. Many progressive communities have already met the state standards.

A strategy for the downstate metropolitan cities should include: (1) continued upgrading of ambulance equipment (including two-way voice radio), and trained personnel; (2) a cooperative assessment of ambulance service needs in the cities and surrounding areas; (3) cooperative business programs with area backup coverage and utilization of business personnel especially for administrative and billing purposes; (4) central dispatch of equipment and ambulance services; (5) involvement with Areawide Emergency Medical Services Plans to support and take advantage of hospital categorization efforts; and (6) better inner-city utilization of existing ambulance resources with development of satellite operations using the same sound principles of operation and business management.

Downstate Rural Areas

Rural downstate has unique problems in providing ambulance services—problems which are not insoluble and, in fact, can be handled on a local basis with proper integration of federal and state support. Support is now available from the federal Department of Transportation (DOT) and is being further stimulated by the activities of the Trauma-EMS Program and made more possible with monies available through the Department of Health, Education, and Welfare (HEW) demonstration contract.⁵ The rural ambulance problem cannot be solved with traditional approaches; new concepts must be developed. The Bureau of Emergency Medical Services

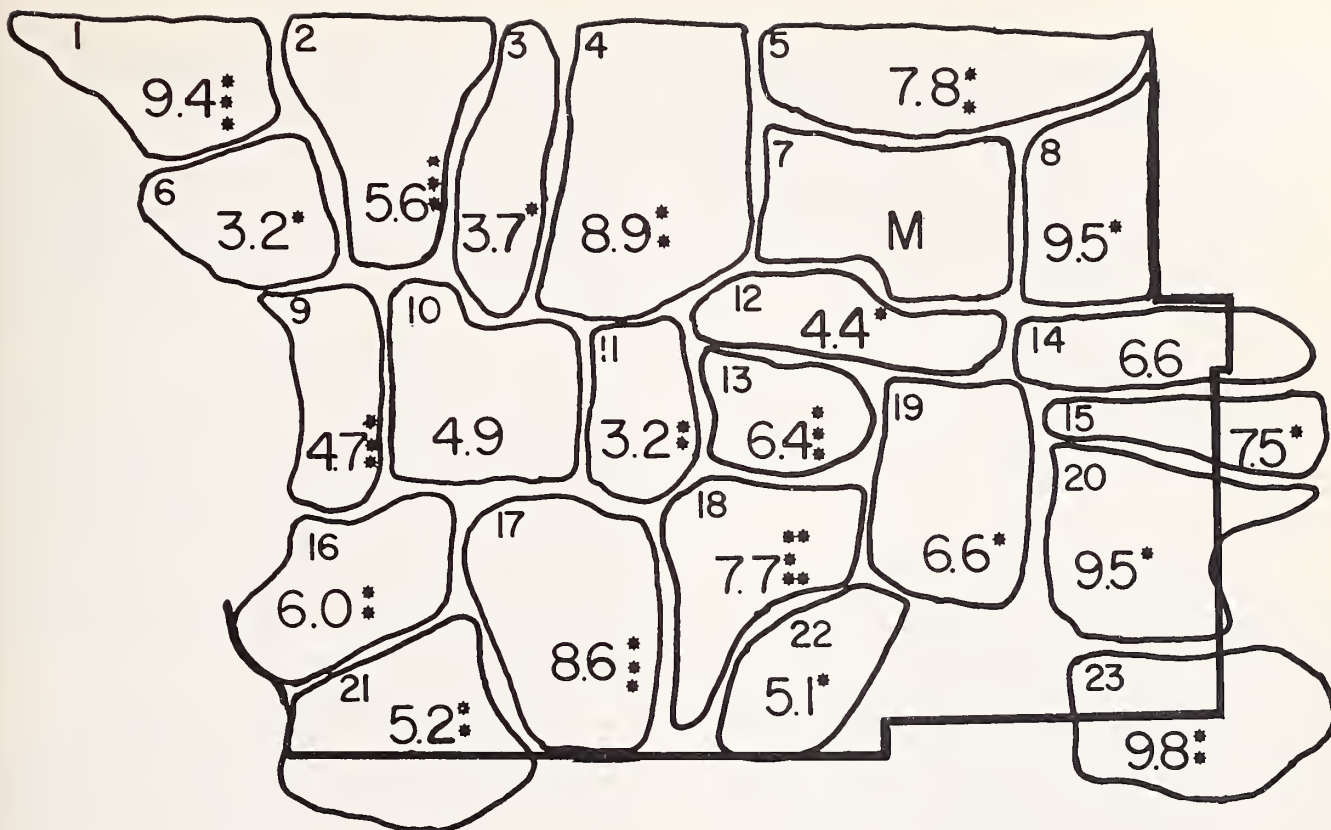


Figure 1. CAPABILITY/NEEDS Rankings for Each of the Ambulance Service Districts in Region I-A. There is no ranking for District 7, a downstate metropolitan district which includes the city of Rockford. Special problems are noted by asterisks.

and Highway Safety (EMS-HS) is actively working with rural downstate communities to maximize their potential for developing improved ambulance services. These efforts have involved: (1) the pooling of resources between rural areas; (2) the utilization of existing medical resources; and (3) implementation of actual ambulance service demonstration projects. Local community leaders have assisted the Bureau of EMS-HS in developing federally funded ambulance grants for standard (DOT) vehicles and equipment.

Ambulance Service Districts

To better approach this problem and to better allocate available local, state, and federal resources, a statewide ambulance service district system has been developed. The entire downstate rural area has been divided into 176 ambulance service districts which have been ranked on a CAPABILITY/NEEDS basis. This ranking has taken into consideration adequate response time, existing medical capability, population density, highway and road accessibility, vehicular accidents and death incidents, and "special" area characteristics. This computed CAPABILITY/NEEDS ranking provides a basis for planning and promoting upgraded ambulance services for

rural communities. Implied in this strategy is the concept of developing existing strengths.

Medical Capabilities

Prior to the development of service area boundaries for rural districts, medical capabilities were identified and ranked for the purpose of ascertaining which would lend itself to supporting an ambulance service. District boundary lines were drawn with an approximate radius of 12 to 15 miles around this central medical resource.

**TABLE I
MEDICAL CAPABILITY RANKING**

(From Highest to Lowest)

- Trauma Center
- Hospital
- State hospital
- Established ambulance service
- Prison infirmary
- Health service operation
- Industrial first aid station
- Rescue operation
- Mortician service (active)
- Nursing home
- Medical clinic
- Forest or park service
- Mortician service (inactive)

Listed above are medical capabilities found in the rural areas with the highest ranking given to

a Trauma Center and the lowest ranking to the mortician ambulance service which does not intend to maintain operations (see Table I). They were ranked in this order to give scoring weight to that capability which can most readily support an ambulance system and operate it in the most efficient manner serving the entire community.

Population

The population of a rural district was estimated by totalling the population of each town and city within the district. Population counts of 25,000 were ranked highest and less than 5,000 lowest.

Highways and Road Access

In each rural district, the number of state or interstate highways, intersections, and interstate access points within the district were ranked and scored. The highest score was awarded to interstate accesses and the lowest score was given to isolated areas with one or no state highways. This ranking takes into account transportation demands and emergency capabilities.

Highway Injuries and Deaths

Highway injuries and deaths were obtained from highway accident maps for the accident year 1972, provided by the Illinois Department of Transportation. The highway injuries resulting in deaths and the total number of injuries were computed to give a numerical score for each district.

Special Problems

The final characteristic considered was any special problems within the district which might influence the extent of ambulance services required. These special problems included the existence of a migrant population, state park, lake or river, airport, camps, or industry. These were not ranked, but each special problem is noted by an asterisk.

CAPABILITY/NEEDS Ranking

To obtain an ambulance service district's CAPABILITY/NEEDS ranking, the following scores were added: medical capability, population, highway injuries and deaths, and highway



Figure 2. Map Showing Districts 1 and 6 in Region I-A (refer to Table II). District 1 has a higher CAPABILITY/NEEDS ranking than District 6.

TABLE II
CAPABILITY/NEEDS RANKING OF DISTRICTS 1 AND 6 IN REGION I-A

	District 1 Galena	District 6 Hanover
CAPABILITY/NEEDS Ranking	9.4***	3.2*
Medical Resource	Hospital	Ambulance Service
Population	10,326	4,110
Highway Intersections	III 20-84 III 20-35	III 84-20
Highway Accidents		
Injuries	64	29
Deaths	5	1
Special Problems	*River *2 Parks	*River

configurations. This final score was computed and qualified for special problems in the district.

Figure 1 shows the CAPABILITY/NEEDS rankings for each of the 23 ambulance service districts in Region I-A, excluding District 7, which is a downstate metropolitan area (includes the city of Rockford).

CAPABILITY/NEEDS rankings are used to compare Districts 1 and 6 in the same region (Figure 2), and are shown in Table II. District 1 is seen to rank higher than District 6.

Figure 3 is a graphical comparison of four districts in Region I-A (Galena, Genoa, Rochelle, and Hanover), using their CAPABILITY/NEEDS rankings.

A Case Study

As reported in this *Journal*,² the Vienna Project in downstate Illinois demonstrates how local ambulance services can be supported with utilization of existing medical resources.

Vienna, Illinois (Region IV), is a small rural town with a population of 3,025 located in Johnson County at the southern tip of the state. Johnson and neighboring Pope County ambulance services had been provided by four independent funeral directors. Last year these morticians gave notice that they were discontinuing ambulance services.

Vienna has a minimum security prison with 24-hour medical dispensary. A plan was worked out by the Trauma Coordinator stationed at the Carbondale Regional Trauma Center to establish, in conjunction with this prison clinic, a 24-hour emergency ambulance service stationed at the prison and serving the bi-county area. This has provided approximately 11,500 people with an around-the-clock ambulance service upgraded

to national standards. This ambulance is dispatched from the regional radio center in Carbondale, or from the Local Trauma Center in Harrisburg or Cairo, and responds to emergencies in the immediate bi-county area. The medical personnel presently employed by the prison function as emergency medical technicians (EMT-A's) and drivers. An EMT-A training program has been sponsored by the town of Vienna in conjunction with the Vienna Prison using NHTSA matching funds. The program trains and utilizes both residents and interested community persons. It provides a positive rehabilitation program at the prison and is a source of additional ambulance technicians.

Continued funding of this ambulance service by Pope and Johnson Counties has been administered by the Bi-County Commission. The commission has established a billing and collection procedure and is responsible for ongoing service and maintenance of the program. This program concept is now being contemplated for several additional countywide ambulance services in southern Illinois.

Presently there are several well-established rural hospital-based ambulance service programs (Lincoln, Macomb, Paris). Similar programs are being evaluated for other rural areas using hospital and emergency department personnel for communitywide ambulance services (Effingham, Mattoon, Quincy, Robinson, Savanna). Also, industrial sites, prisons, and other medical facilities are considering the applicability of this approach to serve their own needs while simultaneously supporting communitywide ambulance services.

Summary

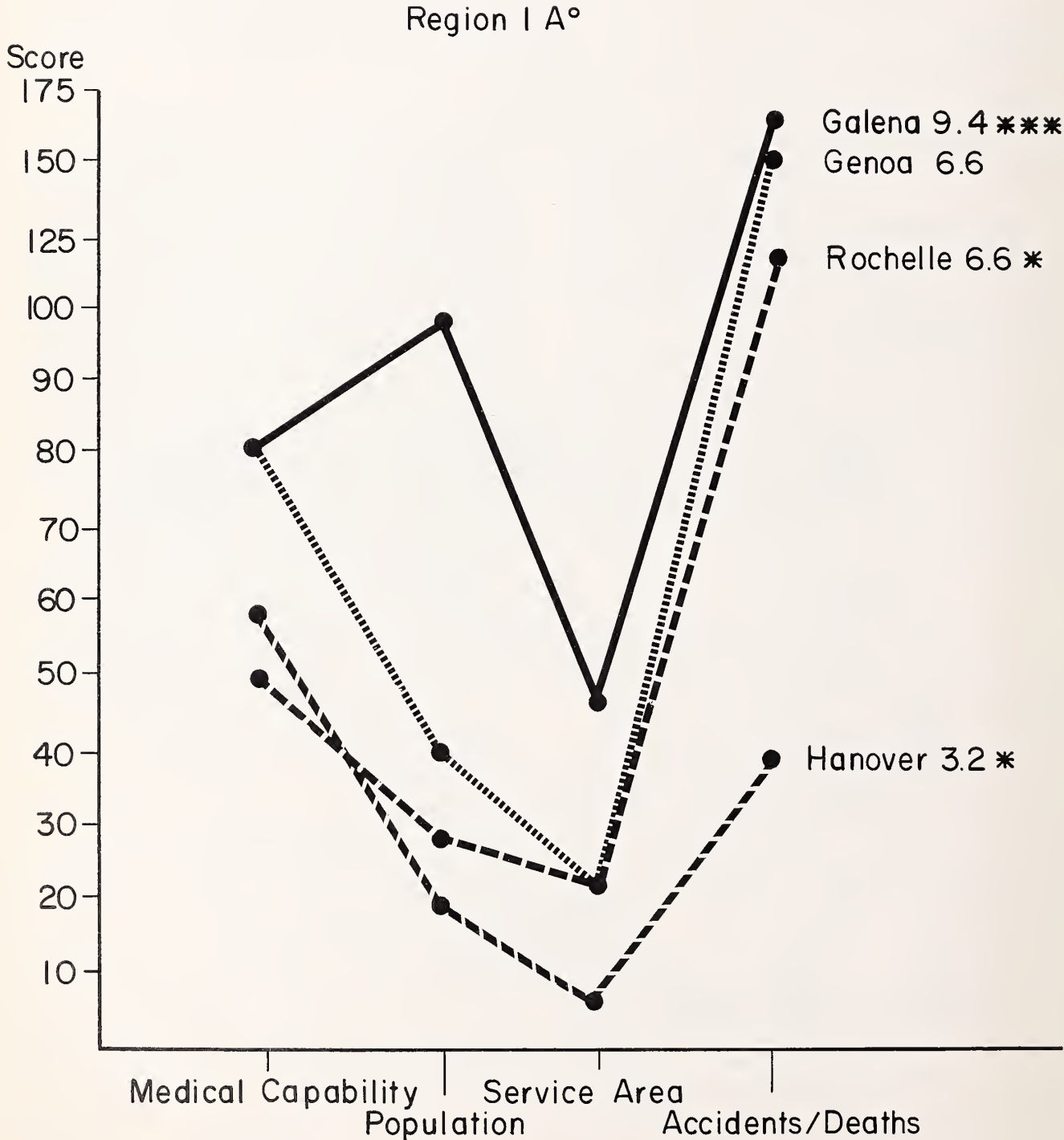
This statewide ambulance strategy has been

presented to local planning groups across Illinois to be used as a tool in approaching the local ambulance service problem. To encourage the upgrading and establishment of viable ambulance services throughout the state, financial support is being provided by the Bureau of EMS-HS for equipment purchase and training of ambulance technicians. Funding for the purchase and support of ambulances also can be collected by local communities through taxation at three governmental levels: county, municipal, and fire protection district. Another important source of funding includes "third-party" payments to ambulance services. Through the coordination of existing medical and financial resources and the utilization of this ambulance strategy, a frame-

work for a complete emergency ambulance coverage in the state can be realized.

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° Excluding Metropolitan Areas-Rockford

Figure 3. CAPABILITY/NEEDS Priority Profile for Four Districts in Region I-A. This figure includes a high and low ranking district and two middle ranking districts within the region.

"Where Have All the Doctors Gone?"*

BY CHARLES J. JANNINGS, III, M.D./FAIRFIELD

In the Holy Scriptures we read that "God gave some to be prophets, some evangelists, some healers and some physicians". You have come here asking "Where are all the doctors?" Medical schools are graduating a higher number of physicians today than ever before and there are more foreign graduates being licensed to practice today than ever before. Where have all the doctors gone?

Let's talk about what doctors look for in a community when they think about practicing there. The physicians you interview here today will want to look at your community's need for a physician. They will assess your community's ability to pay for this need. That is, they will assess its economic stability and viability from the standpoint of whether there has been orderly expansion in medical facilities and personnel; they will look at your community from the standpoint of how they and their families fit into it culturally. Their ethnic background, their religion and the color of their skin will all have a bearing on their ultimate decision.

Like all other professionals, doctors are interested in a community's facilities such as a church of their religion, schools and colleges, libraries, cultural amenities in the arts and sciences, sports and recreation facilities such as water, lakes, skiing, golf, swimming, flying, hunting and fishing.

They will look at the availability of the type of practice they want to go into . . . whether fee for service, solo, partnership, corporation, group clinic closed panel or full-time hospital practice and what the prospects for success are. They will look at the type and the availability of housing, drug stores, nursing homes, hospitals, physician offices and even cable television. They're also interested in the availability of such services as dentists, attorneys, banks, post office and shopping facilities. And when you talk to the physicians this afternoon, keep in mind that the doctor's wife has a tremendous influence over where he eventually practices. What does she look for in a community? She generally wants a friendly environment for her children . . . and one which

offers a challenge and a place for her to grow if she wishes to pursue an intellectual discipline.

Fairfield and Wayne County (Illinois) have all these and more, including clean air, no major crime, and friendly people. Fairfield, a community of 6,000, a county seat in the rural southeast Illinois, realized it had a problem during World War II when many practicing physicians answered the call to the colors, leaving inadequate medical manpower in the community with the nearest hospital 30 miles away. So after the war the community constructed a 100 bed Hill-Burton hospital, raising over \$600,000 locally which was matched with state and federal funds.

Four years later when I was looking for a place to practice, this new, attractive, well-equipped hospital and the presence of nine other practicing physicians in the community convinced me to move to Fairfield.

Over the past 20 years attrition, death, retirement, re-training for a new specialty or subspecialty and subsequent relocation elsewhere has reduced the number of practicing physicians from ten to five of which I am the youngest. The community leaders became quite alarmed three years ago when two physicians left. One, an older man with a large well-established practice, and another one, the youngest and newest doctor who had lived in the community approximately a year.

All-out efforts to attract physicians to our community have been uniformly unsuccessful.

Last year, however, we decided to try a new approach. We attempted to induce medical students to return to Fairfield following their training in return for financial assistance which we would provide during their medical school years when they needed it most. Therefore, the community established a Memorial Fund for medical education through which money is loaned to medical students in return for a promise to return to Fairfield to practice upon completion of residency training. There is a forgiveness clause

*This was the address given at the Second Annual ISMS Doctor's Job Fair, December 3, 1972. Dr. Jannings is a Past President of ISMS.

The 1973 Doctor's Job Fair is scheduled for December 2 at the Sheraton-O'Hare, Chicago. See *Physician Recruitment*, pages 523-524.

in the loan so that for each year the young physician practices in the Fairfield community 10% of the loan will be forgiven for each year he or she practices in Fairfield up to 50% of the loan.

At the present time we have three freshmen and one junior student under contract from the University of Illinois and the program is less than a year old.

When communities talk about their need for doctors they mean family doctors, physicians of first contact, specialists in primary care, internists, pediatricians, general practitioners, OB-GYN, and surgeons who are genuinely interested in people and their problems. They do not need or want superspecialists who limit their practice to the right ear, the left kidney, the posterior lobe of the pituitary or diseases of the hematopoietic system. All *these* things are immediately available in abundance—for instance, in Fairfield I can pick up the phone and immediately contact any one of 5 orthopedic surgeons on the staff of one clinic in a town of 70,000 people 60 miles away.

What the people want and need is a personal physician—a family doctor—who is broadly trained and highly skilled; he knows his capabilities, his limitations and is humble enough to admit them and call for consultation and referral when needed. This doctor *alone* should be capable of caring for 85% of all medical problems and be a member of a team that is capable of caring for 98% of all medical problems. So I plead with you, if you are a highly but narrowly trained subspecialist, unable to find full employment of your skills, to consider retraining for the specialty of family medicine. (You can still offer services in your sub-specialty, but family practice will represent more than 75% of your practice and I guarantee you will be immediately busy!)

Josef Stalin is alleged to have said that material wealth equals the number of engineers times the number of KWH of power generating capacity. I would like to propose this equation: optimal health care equals the number of primary care physicians times the number of medical research and sub-specialty physicians. If this equation is proven true, you can see that if the number of primary care physicians continues to decline—we will have a tough time raising the level of health care delivered to the American people. ◀

ISMS Annual Meeting Slated For April 3-6, 1974

The 134th annual meeting of the Illinois State Medical Society and the 30th annual Midwest Clinical Conference of the Chicago Medical Society will be held April 3 to 6, 1974, at the Conrad Hilton Hotel in Chicago.

More than 15 specialty societies will cooperate in presenting scientific programs during the four-day conference. Six different instructional courses will be offered. Robert T. Fox, M.D., Glenview, is general program chairman for the conference.

Speaker Andrew J. Brislen, M.D., Chicago, will call to order the first session of the ISMS House of Delegates at 3 p.m. Wednesday, April 3. Other sessions of the House will be at 2 p.m. Friday and 10 a.m. Saturday. All members of the society are urged to attend open hearings of reference committees at 7 p.m. Wednesday.

Technical and scientific exhibits will be open from 10 a.m. to 5 p.m. Wednesday through Friday.

Special events during the conference will include a public affairs breakfast on Thursday morning and the annual president's banquet on Thursday evening.

The conference is under the general supervision of a Joint Management Committee composed of Drs. Paul W. Sunderland, Gibson City, chairman; Joseph Bordenave, Geneva; Vincent C. Freda, Chicago; Jacob E. Reisch, Springfield; Harold A. Sofield, Oak Park; Andrew Thomson, Chicago; Fred A. Tworoger, Chicago, and Fred Z. White, Chillicothe.

Mrs. Carell Hutchison, Chicago, is convention chairman for the Woman's Auxiliary, which will conduct its own three-day meeting concurrently with the Midwest Clinical Conference. ◀

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Doctor's News

DON'T ALLOW CHIROPRACTORS TO DO PHYSICALS—Recently published proposed regulations of the Bureau of Motor Carrier Safety, U.S. Department of Transportation, would allow chiropractors to perform physical examinations of drivers of interstate commercial vehicles. It is important that the views of the medical profession be made known about this important matter. Comments should be made, in triplicate, to the Director, Bureau of Motor Carrier Safety, Washington, D.C., citing Docket No. MC-49, Notice No. 73-18. ISMS already has filed an objection and the members may wish to do so, as well as contacting their representatives in Congress.

ILLINOIS SUPREME COURT REVERSES AUTOPSY DECISION—Judgment in the Circuit Court of Cook County, in the case of *Leno v. St. Joseph Hospital*, Chicago, had found that each member of a surviving class must consent to autopsy; that the consent of one member of a surviving class did not bind other members of said class.

The Illinois Supreme Court, on appeal, reversed the judgment of the Circuit Court and held the statutes constitutional. This means that any physician may now perform an autopsy upon the body of a decedent provided he has written authorization from the decedent to do so, or has written authorization from a surviving relative who has the right to determine the method for disposing of the body, as provided for in the statutes. Where two or more persons have equal right to determine disposition, the authorization of only one is necessary, unless before the autopsy is performed any others having an equal right object in writing, or if not physically present in the community by telephonic or telegraphic message to the physician by whom the autopsy is to be performed.

This restores the ability of one member of a surviving class to authorize an autopsy, which had been in doubt as a result of the earlier Circuit Court ruling.

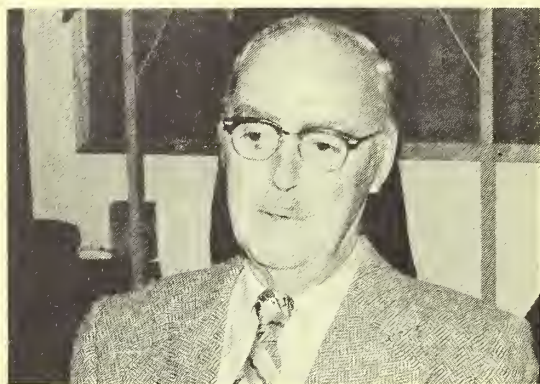
SWANK HEADS AGING DEPARTMENT—Illinois Governor has appointed Harold O. "Hap" Swank as the first Acting Director of the New Illinois Department on Aging. The Department began operation in November and will administer a \$9.5 million program of services to Illinois Senior citizens.

Swank requested that his appointment be only for the period required to get the department underway. From 1934-1971, he served in the state's public aid program and was the first Director of Public Aid for eight years.

PHYSICIANS IN THE NEWS—Roy J. Philipp, M.D., Carbondale, was chosen "Doctor of the Year" by the Jackson County Medical Society.

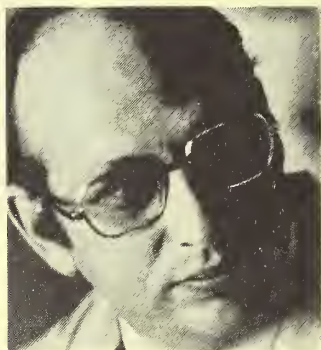
William F. Hyna, M.D., has been appointed Dean of Rush Medical College of Rush University and Vice President for Medical Affairs of Rush Presbyterian-St. Luke's Medical Center in Chicago.

Samuel G. Taylor III, M.D., Director of the Section of Medical Oncology, Division of Medicine at Rush-Presbyterian-St. Luke's Hospital and Professor of Medicine at both Rush Medical College and the University of Illinois, has received the Annual Award for Distinguished Service in Cancer Control presented by the National American Cancer Society and the Illinois Division.



Chester L. Crean, M.D.

Dr. Nadler Receives Award



Henry L. Nadler, M.D., FAAP, Chairman and Professor of the Department of Pediatrics, Northwestern University Medical School and Chief of Staff and head, Division of Genetics, at Children's Memorial Hospital, Chicago, was chosen by the American Academy of Pediatrics to receive one of two E. Mead Johnson Awards in pediatrics.

Dr. Nadler is cited for his original and significant contributions in the field of human amniocentesis, especially as this relates to cytogenetics of the fetus and the prenatal diagnosis of inborn errors of metabolism. He was the first to describe a new inherited metabolic disorder, lysosomal acid phosphatase deficiency, and has recently made a potentially very important discovery bearing on a metabolic defect in the cause of cystic fibrosis.

**Chester L. Crean, M.D., Retires
After 45 Years of Service**

Chester L. Crean, M.D., 71, recently closed his appointment book after 45 years as a physician. For the past 37 years, Dr. Crean has had his office at 1931 W. Irving Park Road, Chicago. He is pleased that his office will be taken over by two women internists.

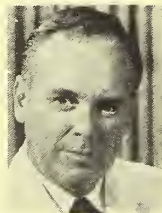
Born and raised near Mattoon (Illinois), Dr. Crean received his medical education at the University of Illinois College of Medicine. He served his internship and surgical residency at Augustana Hospital where he later served as President of the Medical Staff.

Dr. Crean was President of the Northwest-Branch and North Shore Branch of the Chicago Medical Society.

In a recent news article in the **Chicago Today**, Dr. Crean commented on his years as a physician, "What is most satisfying is the confidence the patients place in you; you are important to them, and more than a doctor, you are also a counselor."

He is taking up retirement life in Glenview where he will be near his children and grandchildren.

Surgeons Receive Film Awards



During the 59th Annual Clinical Congress of the American College of Surgeons Lloyd M. Nyhus, M.D., F.A.C.S. (left) and Harry Southwick, M.D., F.A.C.S. (right) each received commemorative plaques for their 25-minute color films which demonstrate extensive work in specialized surgery.

Dr. Nyhus, Professor and Head, Department of Surgery, Abraham Lincoln School of Medicine, Chicago authored the film, "Parietal Cell Vagotomy."

Dr. Southwick, Professor and Chairman, Department of General Surgery, Rush-Presbyterian-St. Luke's Medical Center, was recognized for this film, "Excision and Dissection in Continuity for Malignant Melanoma."

("Doctor's News" continued on page 508)

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritat-

ing symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants

and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

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A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on—



For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides $\frac{1}{4}$ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen[®] with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital ($\frac{1}{4}$ gr.), 16.2 mg. (warning: may be habit forming); Aspirin ($2\frac{1}{2}$ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓜ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. **A-H-ROBINS**

Are You Satisfied With Your CME?

BY LEONARD S. STEIN, Ph.D., EXECUTIVE DIRECTOR
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION

This is the introduction to YOUR PERSONAL LEARNING PLAN, a pamphlet just produced by ICCME, which is intended to assist the individual physician in planning his continuing professional education in a systematic fashion. Any Illinois physician (M.D. or D.O.) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to: Illinois Council on Continuing Medical Education, 360 N. Michigan Ave., Chicago, IL 60601. For non-Illinois physicians, the cost is \$1.00/copy; or 90¢ each in quantities of 100 or more.

While written chiefly for primary-care practitioners—family physicians, internists, pediatricians—YOUR PERSONAL LEARNING PLAN can also be useful to many specialists who ordinarily deal with a smaller range of medical problems.

A unique feature of this pamphlet is a special set of worksheets—similar in form to a patient medical record—to help you think through and record your personal learning plan.

The first printing of YOUR PERSONAL LEARNING PLAN was supported by a grant from the Interstate Postgraduate Medical Association of North America, for which ICCME and Illinois physicians express appreciation.

Are you satisfied that your continuing education efforts are paying off? That you have picked up this booklet suggests a "No" answer—which puts you in the majority of practitioners.* Unhappily, there is no easy way to correct the situation. There is, however, a systematic way to deal with this problem—devise a plan for continuing education that fits your particular needs, interests, and concerns.

The rewards of a systematic approach are fourfold:

(1) you'll know how well you're growing in knowledge and skill. Consequently, you can control that growth in directions you think desirable, and more satisfactorily meet the needs of your patients;

(2) you'll improve your medical competence in ways directly related to the particular configuration of your practice;

(3) the 200-plus hours a year you devote to continuing education will be spent in the most efficient manner possible—with consequent greater return for this investment of your energy and time; and

(4) you'll easily satisfy CME requirements of medical organizations and institutions, and of governmental agencies.

*The Michigan Study of physicians found their greatest frustration in the area of personal and professional growth—i.e., continuing education.¹

Is it Necessary?

Granted the rewards, you still may think, "Developing a systematic plan will take time. Wouldn't I be better off using that time on my reading, or attending a CME course? There's a plethora of CME available; if I just pick out the things that interest me, won't I be learning most effectively?"

Perhaps you will—but you'll never know, because you won't be controlling your professional growth. Central to this consideration is an important fact about contemporary CME that deserves emphasis: its discontinuity. One scholar describes the situation so:

The journal, the annual convention, or the regularly scheduled meeting provide as much continuity as is thought necessary, and even in such cases it is only the method of presentation which is continuous, not the messages brought. Other forms of continuing education usually make up an amalgam of bits and pieces of experience. The content of each activity is based on whatever is, for the moment, new, usually some specific area of knowledge or technique which lies at one of the frontiers of rapidly expanding knowledge or practice. The professional learns one element of novelty; later on, perhaps, he learns another; but the second is not de-

signed to be linked to the first in any meaningful way. The growth of knowledge, the refinement of skills, and the deepening of understanding or of ethical sensitivity are achieved, if at all, by what appears to the outsider to be a zigzag and erratic course.²

Put another way: in college, medical school, internship and/or residency, somebody prescribed a more-or-less integrated set of learning experiences that led you systematically to mastery of medical knowledge and skills. In the process, you had frequent opportunity for evaluation of learning achieved—a crucial element in your progress. Now that you're on your own, it'll be haphazard and perhaps even counterproductive, if *you* don't plan your continuing education.

The Elements of a Good Plan

To prepare a good plan, seven steps are necessary:

1. Determine your needs.
2. Assess your practice.
3. Select specific learning objectives, on the basis of the first two steps.
4. Decide how to achieve each learning objective.
5. Inventory learning resources available to you.
6. Decide on priorities and establish a schedule.
7. EVALUATE your learning achievement.

To use these steps wisely, you'll probably be better off to set up a rather small plan at first. When you start thinking about your NEEDS—*i.e.*, areas of medicine in which you do not feel fully competent—and compare that with the kind of patients you're seeing, you can easily select a dozen or more areas. CUT IT DOWN TO ONE. For example, analysis of your practice may reveal a growing number of skin rashes among your patients, plus a feeling that you're not dealing with them as well as possible. In that case, you might choose two or three learning objectives (Step Three) in the area of allergy. When you've worked through all seven steps and evaluated this first piece of learning, your second plan might well be larger in scope.

A Warning

Little is known about adult learning. Humans differ radically from other living species in their ability to react to an enormous spectrum of stimuli and to adapt behavior accordingly; beyond this, there is no empirical evidence that one approach to learning is superior to any other.

The only generalization one can make safely is that ADULT HUMANS LEARN WHEN THEY FEEL THE NEED—sometimes, it would seem, almost in spite of formal educational efforts.*

In a sense, therefore, the advice in this pamphlet is self-contradictory. On one hand, it offers a single systematic approach that will presumably be useful to most people. On the other hand, it encourages you to plan an *individualized* learning program, one unlike that of any other physician. Thus, read what follows with a critical eye. It is useful for many—but it may not be for you. If it is of no use, reject it instantly. If you find some value in it for yourself, use the parts that are useful, adapting the basic plan to your way of learning.

This plan is presented as a series of *separate steps*—but you'll see that they merge imperceptably, representing, at best, arbitrary points in one continuous process. The steps will occur both simultaneously and in order—depending largely on your personal needs. The best that this analysis of the process can do is to suggest enough of its nature so that you can adjust it to yourself.

This warning applies particularly to the worksheets (see a sample of the first one, at the end of this introduction). They can be useful aids in developing a systematic plan, and they provide a record of decisions that you will find useful in assessing your progress. If they *don't* prove helpful—ignore them, and keep a record of your Learning Plan in any format that is most efficient for you.

Preparation

Once you decide that it's worth the time required to develop a Personal Learning Plan, you'll find these few preparations helpful:

1. Set up a "Learning File"—preferably the top drawer in a file cabinet next to your desk. Have your secretary set up three sections:
 - a) *General*: One folder labeled "Ideas", plus a folder for each of the seven steps involved in developing your Plan.
 - b) *Sources of CME*: A folder for each learning source you decide is important—medical schools, specialty societies (including the American Academy of Family Practice), other organizations.
 - c) *Learning Material*: A folder on each subject area or topic that interests you.
2. Set aside a definite schedule for the development of your Personal Learning Plan. Two to

*The best study yet of adult learning habits produced a surprising fact: of all adults engaged in systematic learning (including degree programs), fully a third were doing so entirely on their own.³

three hours a week is likely to be optimal. DO NOT work through the entire plan in one sitting; rather, take it step-by-step, over a period of some weeks or even months. DO NOT feel that you must complete the entire Plan before continuing your regular learning activities. Depending on your personality and work-habits, you might find it best to work through Steps One, Two, and Three with some speed—and then take a longer period on Steps Four and Five. How long you spend on learning activities and on Step Seven depends on your decisions in the first five Steps.

Look Ahead

When you've completed your Personal Learning Plan, set it aside with a "flag"—for your secretary to remind you to look at it again, six months or so later. A good Personal Learning Plan is one that grows along with you. Once you've completed *one* set of planned learning experiences, you'll find yourself eager to plan the

next set—to bring your Personal Learning Plan up-to-date. So, start over again, working through Steps One through Seven (and the second plan will take less time to complete than the first.) You're likely to find yourself developing two, or three, or even five or six learning plans. SAVE EACH ONE; reviewing old ones will give you the crucial personal satisfaction of being able to see, directly and personally, how much growth you've enjoyed. ◀

References

1. Floyd C. Mann, *et al.*, "The Michigan Physician and His Continuing Education," *Michigan Medicine*, Vol. 69, No. 21 (November, 1970); and "The Michigan Physician: His Work Needs and Opportunities," *loc. cit.*, Vol. 69, No. 23 (December, 1970).
2. Cyril O. Houle, "To Learn the Future," *Medical Clinics of North America*, Vol. 54, No. 1 (January, 1970), pp. 5-17.
3. Johnstone, John W. C., and Rivera, Ramon J. *Volunteers for Learning* (Chicago: Aldine Publishing Co., 1965).

**STEP ONE
DETERMINE YOUR NEEDS**

Adult learning occurs only when the individual feels a need to learn. Accordingly, the first step is to determine your learning needs.

Worksheet A, *below*, is offered to help you begin this analysis. Start by jotting down whatever learning needs occur to you. DON'T worry about whether your list includes little or big items, or whether they're specific enough to work on. Do double-space your entries, to allow room for later revision. (If the two pages provided aren't sufficient, use any lined paper.)

For suggestions on formal methods to analyze your needs, *see* section on "Needs Assessment," (*not included in this article*).

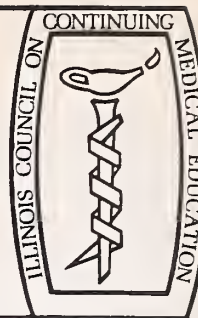
WORKSHEET A: NEEDS LISTING

You're likely to end up with a list too long to be workable—so the last part of Step One is to *prune* your final list, and then number the remaining items in order of importance. (Any items you think important—but not immediately so—save for your *next* Learning Plan.)

Note that Worksheets C and E (*NOT INCLUDED IN THIS ARTICLE*) provide space for only *four* learning needs. Take that as an outside limit; if your needs-analysis produces a larger number, cut it down to practicable size.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

DECEMBER

Cardiology

ACUTE CARDIAC CARE

For: All physicians. 3-day course, Dec. 5-8, 1973, Chicago, Ill.

Hrs. of Instruction: 21. **CME Credit:** AMA Category 1. **Fee:** \$100.00. **Registration Limit:** 80.

Sponsor: Cook County Graduate School of Medicine.

Write to: Cook Co. Grad. Sch. Med., 707 S. Wood St., Chicago, IL 60612.

Congenital Anomalies

FOURTH TUTORIAL ON HUMAN CHROMOSOMES

For: All physicians. 5-day conference, Dec. 4-8, 1973, Univ. of Chicago Center for Continuing Educ. Chicago, Ill.

Hrs. of Instruction: 50. **Fee:** \$300.00. **Registration Limit:** 100.

Sponsor: International Academy of Cytology.

Write to: International Academy of Cytology, 5841 S. Maryland Ave., Chicago, IL 60637.

Endocrinology

ENZYMOLGY

For: All physicians. 5-day conference, Dec. 10-14, 1973, Chicago, Ill.

Hrs. of Instruction: 30. **Fee:** \$35.00. **Sponsor:** American Society of Clinical Pathologists.

Write to: Amer. Soc. Clin. Path., 2100 W. Harrison, Chicago, IL 60612.

Internal Medicine

RECURRENT KIDNEY STONES

For: All physicians. 4th lecture in Frontiers of Medicine series. Dec. 12, 1973, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instruction: 3. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$15.00.

Sponsor: University of Chicago.
Write to: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

JANUARY

Cardiology

ECHOCARDIOGRAPHY WORKSHOP

For: Cardiologists. 4-day symposium, Jan. 14-17, 1974, Indianapolis, Ind.

Hrs. of Instruction: 26. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$125.00. **Registration Limit:** 50.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Endocrinology

CLINICAL ENDOCRINOLOGY

For: Family Physicians, Pediatricians, Internists. Symposium, Jan. 16, 1974, Indianapolis, Ind.

Hrs. of Instruction: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$35.00.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Internal Medicine

ARTHRITIS

For: All physicians. Lecture, seminar. Jan. 11, 1974, 10 a.m., Bethesda Hospital; Jan. 11, 6 p.m., Lincolnwood Hyatt House; Jan. 12, 10 a.m., Forkosh Memorial Hospital, Chicago, Ill.

Hrs. of Instruction: 5. **CME Credit:** AAFP. **Fee:** \$15.00 (non-staff, lecture & dinner). **Deadline for Registration:** Jan. 5, 1974.

Sponsor: FAB³-CME

Write to: Mr. Neil Glass, Bethesda Hospital, 2451 W. Howard St., Chicago, IL 60645; (312)761-6000

Your Personal Learning Plan
is now available—see page 499.

FEBRUARY

Emergency Care

MEDICAL EMERGENCIES

For: All physicians. 6th lecture in Frontiers of Medicine series. Feb. 13, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instruction: 3½. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$15.00.

Sponsor: University of Chicago.
Write to: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

Family Medicine

MEDICINE FOR TODAY (Spring Series)

For: Family Physicians. Series of correlated lectures, Feb. 28-Mar. 28, 1974, at these cities: Belleville, Berwyn, Centralia, Champaign, Chicago (North, Near West, South West), Elgin, Hinsdale, Kankakee, Melrose Park, Park Ridge, Peoria, Rockford, Rock Island, Springfield.

Hrs. of Instruction: 12. **CME Credit:** AAFP. **Fee:** \$45.00 (members); \$50.00 (non-members). **Deadline for Registration:** Feb. 1, 1974.

Sponsor: Illinois Academy of Family Physicians.

Write to: IAFP, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

Internal Medicine

FRED PRIEBE MEMORIAL SYMPOSIUM ON ARTHRITIS

For: Internists, Family Physicians. Symposium, Feb. 6, 1974, Indianapolis, Ind.

Hrs. of Instruction: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$35.00.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

DECEMBER

Nuclear Medicine

GAMMA CAMERA WORKSHOP

For: Radiologists & Technicians. 3-day symposium, Dec. 13-15, 1973, Indianapolis, Ind.

Hrs. of Instruction: 23. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$100.00. **Registration Limit:** 30.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Obstetrics/Gynecology

GYNECOLOGICAL

LAPAROSCOPY

For: All physicians. 5-day course, Dec. 3-7, 1973, Chicago, Ill.

Hrs. of Instruction: 15. **Fee:** \$200.00. **Registration Limit:** 8.

Sponsor: Cook County Graduate School of Medicine.

Write to: Cook Co. Grad. Sch. Med., 707 S. Wood St., Chicago, IL 60612.

GYNECOLOGIC ENDOCRINOLOGY (Menopause)

For: All physicians. Lecture, seminar. Dec. 7, 1973, 10 a.m., American Hospital; Dec. 7, 6 p.m., Lincolnwood Hyatt House; Dec. 8, 10 a.m., Bethesda Hospital, Chicago, Ill.

Hrs. of Instruction: 5. **CME Credit:** AAFP. **Fee:** \$15.00 (non-staff, lecture & dinner). **Deadline for Registration:** Dec. 3, 1973.

Sponsor: FAB³-CME

Write to: Mr. Jack Pardee, American Hospital, 850 W. Irving Park Rd., Chicago, IL 60613; (312)LA5-6780.

SURGICAL & RADIATION THERAPY OF GYNECOLOGICAL MALIGNANCIES

For: Specialists. 5-day course, Dec. 10-14, 1973, Chicago, Ill.

Hrs. of Instruction: 30. **Fee:** \$150.00. **Registration Limit:** 16.

Sponsor: Cook County Graduate School of Medicine.

Write to: Cook Co. Grad. Sch. Med., 707 S. Wood St., Chicago, IL 60612.

Otolaryngology

OTOLARYNGOLOGY FOR THE PRIVATE PHYSICIAN

For: Family Physicians, Pediatricians, Internists. Symposium, Dec. 5, 1973, Indianapolis, Ind.

Hrs. of Instruction: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$35.00.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

JANUARY

Obstetrics/Gynecology

SEX AND THE MEDICAL PRACTITIONER

For: All physicians. 5th lecture in Frontiers of Medicine series. Jan. 9, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instruction: 3. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$15.00.

Sponsor: University of Chicago.

Write to: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Jan. 17, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. **Write to:** Raymond L. Del Fava, M.D., Secretary, Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

Surgery

PRIMARY & METASTASTIC BRAIN TUMORS

For: Surgeons, Internists, Pediatricians, Family Physicians. Symposium, Jan. 30, 1974, Indianapolis, Ind.

Hrs. of Instruction: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$35.00.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Trauma

HOSPITAL PROGRAM ON GENERAL SURGERY/TRAUMA

For: All physicians. Monthly clinical program, Jan. 15, 1974, 8 p.m., Passavant Pavilion, Northwestern Memorial Hospital, Chicago, Ill.

Hrs. of Instruction: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons.

Write to: Arne Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

FEBRUARY

Internal Medicine

LIVER DISEASES

For: All physicians. Seminar, lecture, Feb. 15, 1974, 10 a.m., Forkosh Memorial Hospital; Feb. 15, 6 p.m., Lincolnwood Hyatt House; Feb. 16, 10 a.m., Bethany Methodist Hospital.

Hrs. of Instruction: 5. **CME Credit:** AAFP. **Fee:** \$15.00 (non-staff, lecture & dinner). **Deadline for Registration:** Feb. 9, 1974.

Sponsor: FAB³-CME

Write to: Mr. S. Plotner, Forkosh Mem. Hospital, 2544 W. Monroe Ave., Chicago, IL 60618; (312)267-2200.

Psychiatry & Neurology

COMBINED PSYCHIATRIC & NEUROLOGIC DISORDERS

For: Psychiatrists, Pediatricians, Neurologists, Family Physicians. Symposium, Feb. 13, 1974, Indianapolis, Ind.

Hrs. of Instruction: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** \$35.00.

Sponsor: Indiana University School of Medicine.

Write to: Mr. John Roscoe, Ind. Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Feb. 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society.

Write to: Raymond L. Del Fava, M.D., Secretary, Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

Trauma

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, Feb. 19, 1974, 8 p.m., Cook County Hospital, Chicago, Ill.

Hrs. of Instruction: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons.

Write to: Howard Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

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Finding available courses that fit your needs is always difficult, even in so brief a listing as this one. To ease this problem, ICCME has arranged for you to obtain an *Individualized CME Calendar* from the University of Wisconsin. For a small fee, you can receive a computer print-out of courses in the *subject-area* (disease category) of your choice,

meeting at *times* and in *places* convenient to you—plus *home study material* (tapes, slides, textbooks).

To keep the fee small, it is necessary to use a special computer request form, supplied free by ICCME. For a copy, write "*Individual CME Calendar*" on your prescription form, and mail to ICCME (*address on facing page*).



medical legal review

The Hospital Practice of Medicine

BY DONAL D. O'SULLIVAN, M.D., J.D. AND HERMAN WING, M.D., LL.B./CHICAGO

The hospital has undergone progressive and increasingly rapid change in its mission, in the type of patient supported, and in the type and makeup of its staff. Some hospitals have assumed the status of an entity in their own right to which people refer as the source for the medical care they wish to receive. Such an attitude is particularly frequent with regard to the teaching hospital, the large urban medical school-affiliated hospital.

Even in the absence of a definitive teaching program or affiliation with a university medical school, the community hospital in some of the larger rural communities and in the suburbs often is the sole or main source of many of the support functions necessary for intelligent modern practice. This is particularly so for diagnostic radiology and pathology support; and even more so for the newer modalities that have been more recently introduced into clinical practice, such as inhalation therapy and pulmonary function testing, physiotherapy, electroencephalography and electromyography. The provision of such services requires performance of his professional function by a physician.

Hospital Control of Physicians

In a New York case (*Bing vs Thunig*, 2 NY2d 655, 1957), the court stated that the hospital could no longer deny the patient recovery by washing its hands of liability for a bad result of therapy used in treatment of a patient and attempting to transfer all such liability to the individual house physician; frequently an impoverished doctor in training. Judge Fuld, in his

decision in this case, effectively demolished that hospital argument when he said:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

Judge Fuld's analysis is good and undoubtedly applicable to certain large municipal and university connected teaching hospitals. However, the above was quoted by the Illinois Supreme Court in its landmark decision in *Darling vs Charleston Community Hospital* (33 Ill 2d 326, 1965) as justification for the court holding the Charleston Hospital liable for the unfortunate result to the plaintiff's leg. At the time that Kenneth Darling was treated in Charleston Memorial Hospital it had 45 beds. It did not have interns or residents, it did not have an employed house staff, and the physician concerned in the case was not an employee of the hospital—he was a member of the medical staff on call for the emergency room.

DONAL D. O'SULLIVAN, M.D., J.D. is Director of Laboratories, Augustana Hospital and Health Care Center, Chicago. HERMAN WING, M.D., LL.B. is Director of Physician Medicine and Rehabilitation, Illinois Masonic Medical Center, Chicago. Both physicians/lawyers serve on the Medical Legal Council of the Illinois State Medical Society.

There was no master-servant relationship between hospital and physician, and therefore no *respondeat superior*. This case actually turned on the contents of the hospital bylaws, and the requirements of the Joint Commission on Accreditation of Hospitals and the Illinois Hospital Licensing Board for organization and operation of hospitals—and the demonstration that the hospital had failed to abide by the strictures of these instruments as to internal control mechanisms.

Some recent cases would seem to support the concept of hospital responsibility for medical functions. In *Lundberg vs Bay View Hospital* (191 NE2d 821, 1963), the Supreme Court of Ohio ruled a hospital liable to the patient for the negligent misdiagnosis by an independent contractor pathologist of biopsy tissue as cancer—as the result of which diagnosis a hysterectomy was done.

. . . The biopsy material was submitted to a Dr. Haws, a pathologist, who had a salary contract with the hospital to do pathological work but who was ostensibly connected and associated with the hospital. The bills covering Haws' services to hospital patients were rendered by the hospital, and his pathological reports were made under the name of the hospital. . . .

There can be no doubt that the jury found . . . that the hospital by its conduct represented and induced the belief that Haws was in its employ as a part of its regular establishment, whereby it was estopped to successfully claim otherwise.

In a more recent case (*Beeck vs Tucson General Hospital*, 500 P2d 1153, 1972), a radiologist with a written independent contractor relationship with his hospital was held to be an employee of the hospital and the hospital was liable to the plaintiff under the doctrine of *respondeat superior* for the negligent failure to apply the descent-arresting stop to an X-ray machine with the resultant striking of a needle placed in the subarachnoid space of the spine.

In reversing the trial court and remanding the cause for further action the appellate court pointed out that the radiologist and his partner were under contract as "co-chairmen" of the hospital department of radiology and had entered into a written agreement to provide professional medical services in their particular specialty for the hospital from and after May 1, 1967, for a five year term. The hospital paid the doctors 33⅓% of 95% of the gross revenue of the X-ray department, calculated on a calendar month basis. The hospital billed for the radiologist's services. The doctors received no other compensation and agreed not to engage in private practice during the term of the agreement with the exception that they could assist a specific other

physician in his practice during times of illness or vacation; providing the efficient operation of the hospital radiology department was not impaired.

In each of these instances a hospital was found liable for the errors of professional personnel who were performing professional acts.

Control of Medical Practice

A recent development is the establishment of satellite ambulatory care centers by hospital organizations in which out-patient care is rendered. Such installations are offering out-patient radiology, pathology, pulmonary diagnostic and therapeutic modalities, and physiotherapy support at locations geographically distant from the parent hospital but dependent on the parent's equipment and personnel. It is evident that insofar as such centers perform medical acts, they are completely dependent on physician-employees for their performance. These physician-employees are very frequently salaried. This is, of course, the practice of medicine by hospitals and as such, gives rise to numerous ethical problems for the participating physicians and some legal problems for the courts. Where there is statutory prohibition of the practice of medicine by a business corporation, the nature of the entity must be defined away or alternatively, the legislature must modify the statute.

To define the activities of such ambulatory care centers as not being the practice of medicine is difficult. In the landmark decision of *Iowa Hospital Association vs Iowa State Board of Medical Examiners* (IA Dist Ct, Polk Co, Docket No 63095, Equity), the court, in a definitive statement, found specifically that pathology and radiology are recognized specialties in the practice of medicine; that pathologists and radiologists are engaged in the practice of medicine in their activities as shown by the evidence; that technicians in the conduct of the procedures, are in fact, serving as the hands of the pathologist, radiologist or other physician in charge; and that when these services are not under actual physician control and supervision, the quality of the services may suffer. It seems obvious that what was stated specifically as to pathology and radiology would apply to even more patient centered activities such as pulmonary evaluation and therapy and physiotherapy.

In much the same context is the recent (1971) opinion of the Attorney General of the State of California (54 Op Atty Gen 126) which interpreted California law to the effect that a non-

profit or proprietary hospital may not employ licensed physicians to furnish medical services and that a licensed charitable or eleemosynary institution may employ physicians and surgeons on a salary basis provided that "no charge for professional services rendered patients is made by such institution."

The alternative approach is that taken by New York, where the legislators, through the Membership Corporations Law, provides for the incorporation of hospitals—which then possess "legislative authority to practice medicine by means of its staff of registered physicians and surgeons" as stated by Judge Bartlett in *People vs John II. Woodbury Dermatological Institute* (85 NE 697, 1908), the leading New York case recognizing that hospitals are exempt from the general legislative prohibition of the practice of medicine by a corporation.

Both the establishment of satellite centers and the increasingly frequent employment of physicians by hospital corporations betoken a profound change in the relations between hospital management and hospital physicians. Much of this can be traced to the *Darling* decision in Illinois, which has been interpreted to mean that the hospital corporation is responsible for the quality of medical care within the hospital directly and therefore should control it directly through salaried employed physicians.

It is frequently overlooked, however, that the Court in *Darling* was quite explicit in stating that the pertinent issue was the liability of the hospital "in failing, through its medical staff, to exercise adequate supervision over the case." This specification that the hospital acts, and should act, in this matter through its medical staff has been ignored in many of the comments on this case. To redress this oversight the Illinois State Medical Society at its 1973 Annual Meeting adopted a resolution clarifying this relationship (Addition to Res 73M-42, Ref Comm on Gov Affairs and Legal Services):

"The practice of medicine is the physician's legal prerogative and responsibility. The quality of medical care in a hospital should be maintained by and through its medical staff; in helping to insure the quality of

medical care, each hospital has the duty to cooperate with and assist its medical staff in developing procedures to accomplish this end."

Even more pertinent is the holding in a 1972 case (*Moore vs Board of Trustees of Carson-Tahoe Hospital*, 495 P2d 605, Nev), in which the court mandated this function in these words:

". . . It is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution."

Conclusions

It seems obvious that the polarization and antagonism between medical staffs and physicians on the one hand and the hospital corporation, its administrators and its Board of Trustees on the other is farther advanced than was thought possible by the majority of the medical profession, even so recently as a year ago. It is also obvious that the medical community, at this writing, is still not accustomed to thinking of the hospital in antagonistic terms; and that there is still a great deal of confusion among medical ranks. It is to be hoped that the physicians and the hospital governing bodies and administrations here in Illinois will recognize that they share their problems—particularly with the advent of the PSRO mechanism—and it would be wise to join together to solve these problems. It seems evident that no "solution" that strips the physician of his responsibility for, nor authority over, the care of his patient will succeed. It also seems evident that the physician—individually and collectively—must partake of the administrative and fiduciary burdens now thrust on the hospital organization by the third party payor—whether governmental or not; and by the external review mechanism, whatever its final form may be.

The ultimate pattern for the practice of medicine is still unclear. It will be shaped by the decisions of the physicians, and of the hospitals in the coming few years of development. The impact of government on these decisions will be significant, but it need not be determinative. ◀

Food For Thought

Large organizations need stability. But when there is turmoil leaders who are unable to assess the tenor of the times are in danger of making decisions which can be harmful and even destructive. It is essential for survival to have an understanding of the national will and an ability to bend with gusts of irrational emotion without destruction of basic principles. And what is true for government, church, college, union and business is also true for professional groups. (L.L.L. Golden.: "The Private Sector In An Environment of Rapid Change." *The Jl. of the Medical Assn. of the State of Alabama* (July) 1973, pgs. 23-28).

Must vasodilators
and therapy for
other diseases
come into
conflict?



not if the vasodilator is

VASODILAN[®]
(ISOXSUPRINE HCl)

the compatible vasodilator...
no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

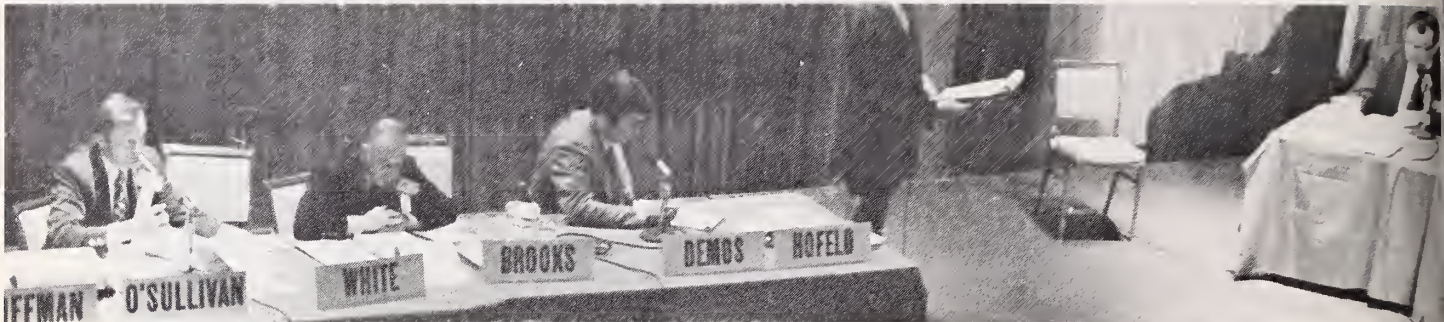
Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1973 Leadership Conference Focused on Professional Liability and Government and Medicine



“Doctor on Trial” was reenacted by the Illinois Bar Association which presented the plaintiff and defendant sides to a malpractice case.



Navy Capt. Joseph P. Kerwin, M.D., presented ISMS President Willard C. Scrivner with a picture he took while on Skylab I mission. Dr. Kerwin was presented an Honorary Membership into the Illinois State Medical Society by President Scrivner.

October 21, 1973
 Drake Hotel
 Chicago

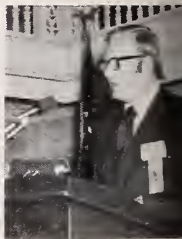


Robert L. Dean, Vice President, Regulatory and Government Affairs, Smith Kline & French Laboratories, presented a luncheon speech on “FDA and the Physician: The Dialogue Deepens.” Smith, Kline and French provided the luncheon for the more than 220 people in attendance.

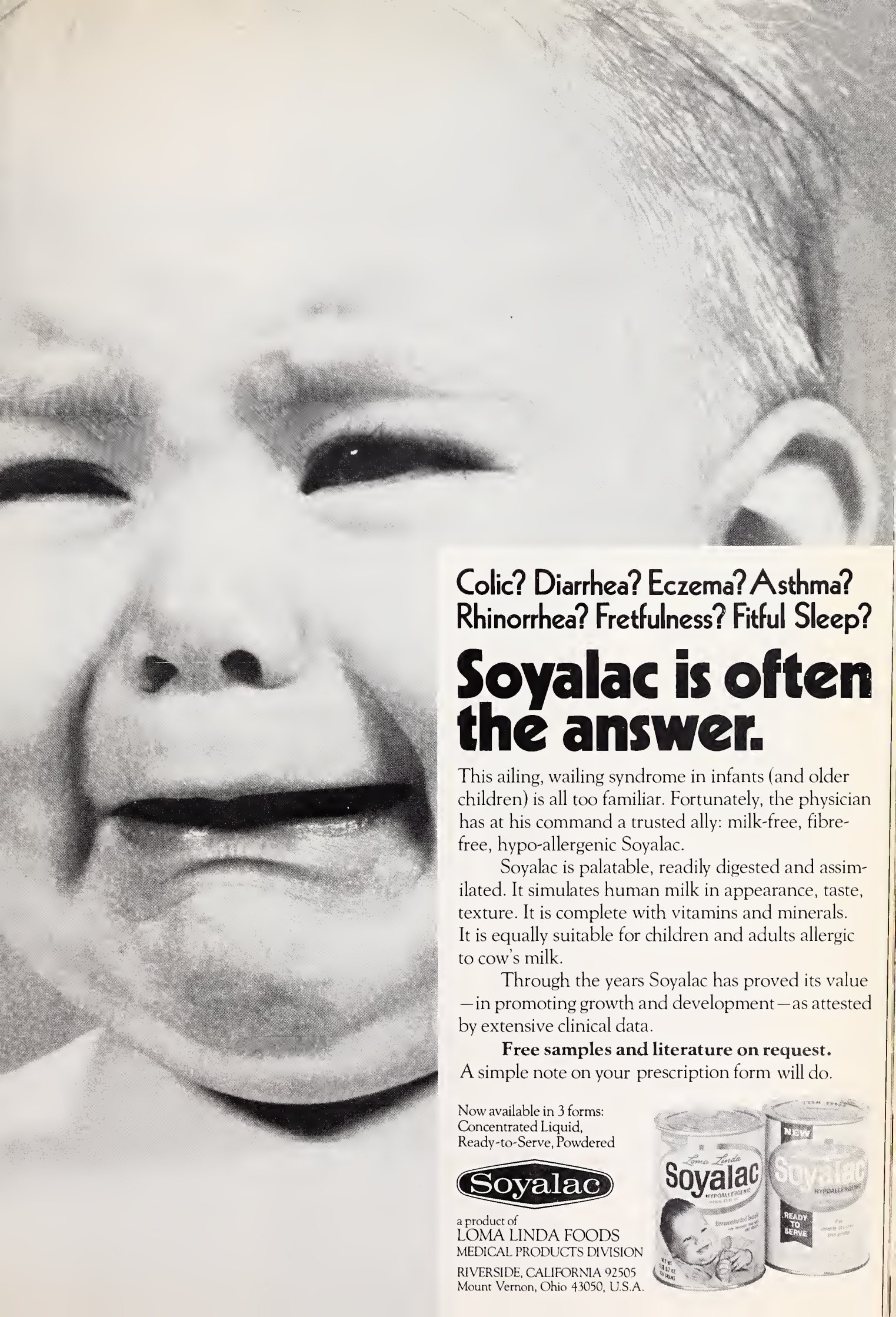


C. A. Hoffman, M.D., immediate Past President, AMA, spoke on “The Malpractice Mess.”

“Health Care: A View From the Statehouse” was the theme of the speech given by the Honorable Neil Hartigan, Lieutenant Governor, State of Illinois.



The Illinois Governor Daniel Walker’s “Health Cabinet” discussed Illinois health programs and problems.



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This ailing, wailing syndrome in infants (and older children) is all too familiar. Fortunately, the physician has at his command a trusted ally: milk-free, fibre-free, hypo-allergenic Soyalac.

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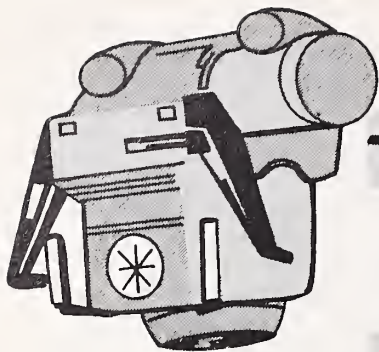
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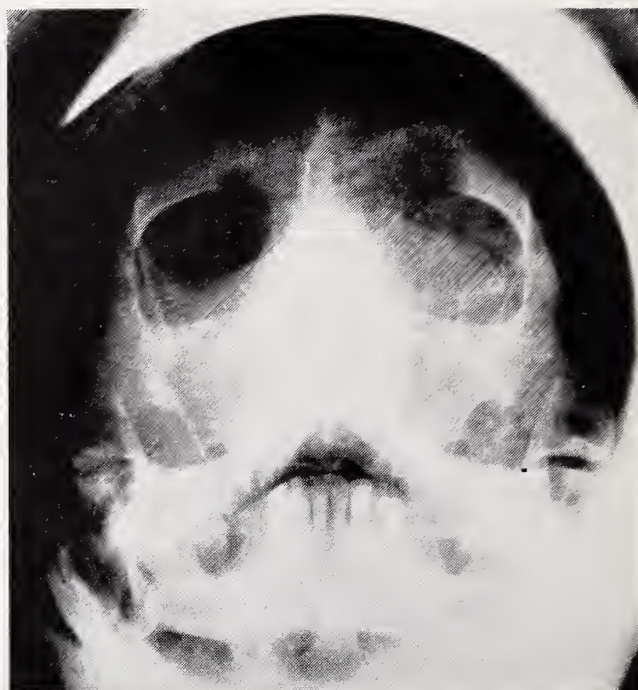
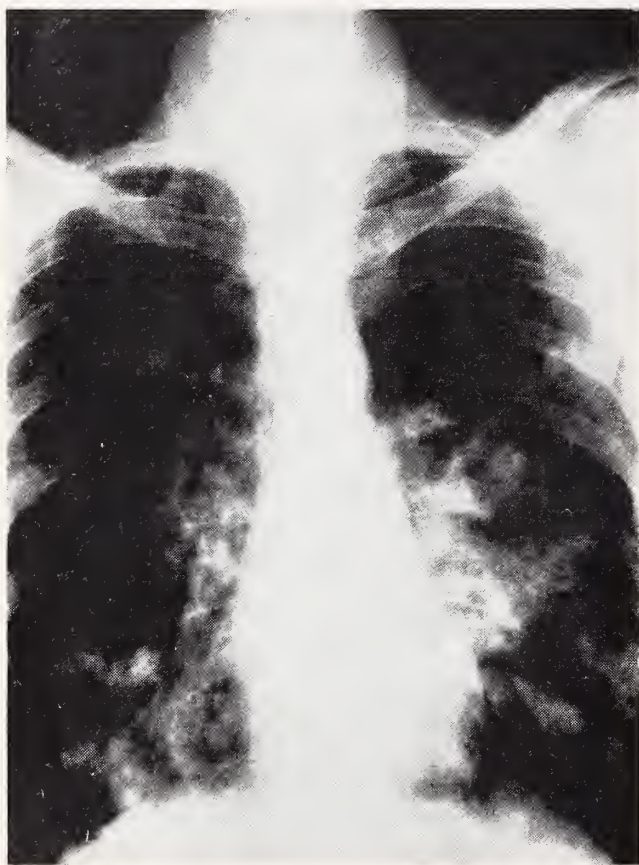
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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



A 49-year-old male was admitted to the hospital with purulent nasal discharge and a necrotic lesion of the hard palate. Physical examination revealed a cachectic toxic male patient with swelling over the maxillary antrum and an abscess involving the medial aspect of the right eye.

What's your diagnosis?

1. Carcinoma of the paranasal sinus with metastasis.
2. Chronic sinusitis with bronchitis.
3. Wegener's granulomatosis.
4. Polyarteritis Nodosa.

(Answer on page 519)



Placidyl® (ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug, such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432



Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often suffered by the elderly. Anxiety and agitation might be the cause. Or the effect. In time that can be determined. But tonight one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

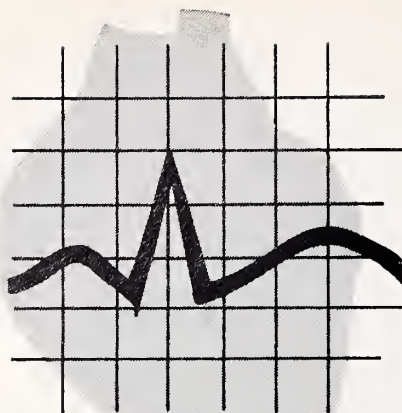
If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

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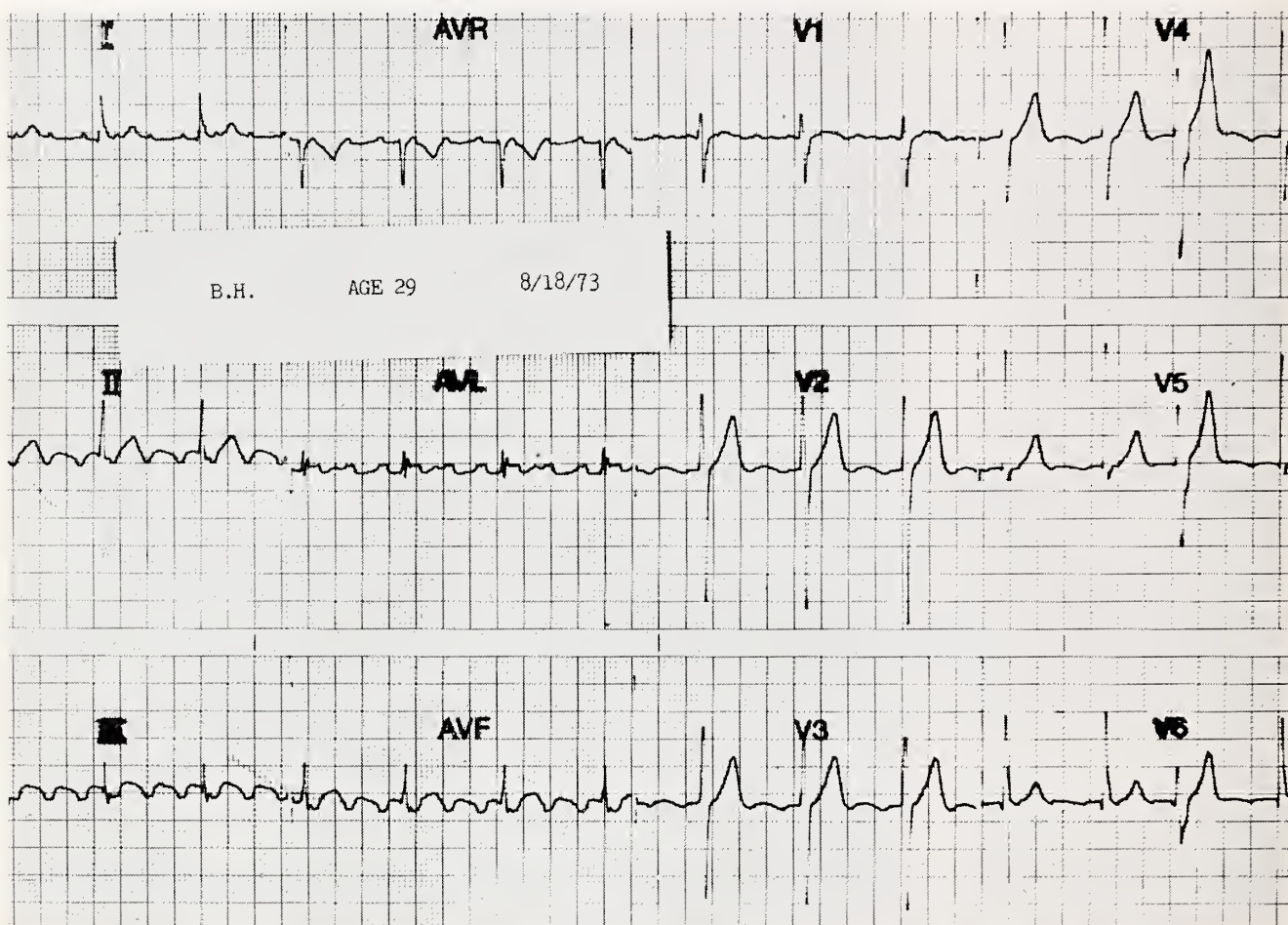


(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)



ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine



A 29-year-old man with rheumatic heart disease and severe mitral valvular regurgitation was digitalized for congestive heart failure. Six months later he developed gastroenteritis that lasted three days. Nausea and vomiting persisted, and he came to his physician for an examination. Serum electrolyte imbalance was found with a serum potassium of 2.0 mEq/liter.

Questions:

1. The ECG taken at this time shows:

- A. Left ventricular hypertrophy
- B. Normal sinus rhythm
- C. Atrial tachycardia with a 3:1 AV block
- D. One premature ventricular beat or an aberrantly conducted supraventricular beat
- E. Junctional tachycardia

2. The treatment in this case would most likely include:

- A. Stopping digitalis
- B. Administering potassium chloride
- C. Increasing digitalis
- D. D.C cardioversion
- E. None of the above

(Answers on page 518)

Editorials



Opportunistic Infection

In our desire to save the unfittest, so to speak, we've encountered new problems in dealing with tracheotomy tubes, intravenous setups and catheters, ventilators, and other gadgets required in the modern management of intensive care. Opportunistic infection is one of these. Definitions of these infections vary, but according to Hillas Smith,¹ ". . . some claim that the term should be used to describe infections with rare or exotic organisms not normally pathogenic; others reserve its application to infection in patients in whom impairment in the body's protective mechanisms is demonstrable." In other words, we give these microbes "the opportunity" to take over.

For practical reasons, opportunistic infections result from microorganisms, both traditional pathogens and those that in the past might be considered nonpathogenic. We now have repositories of resistant organisms derived from ill patients treated with a multitude of antibacterial agents. Much of this stems from the routine use of antibiotics in the prophylaxis and treatment of acute respiratory illnesses. The same can be said of the routine administration of antimicrobial agents when a catheter is placed in the bladder. It alters the bacterial flora of the urine so that sensitive strains of *Escherichia coli* are replaced by resistant staphylococci and pseudomonas. Another example is the treatment of infections in acute leukemia. When successful, the prognosis is improved, but if not, septicemia due to pseudomonas, resistant staphylococci, fungi, and other disturbing pathogens may develop.

An opportunistic infection does not necessarily cause the usual symptoms of an ordinary infection. The diagnosis of the former must be based on an awareness of the circumstances in which it (opportunistic infection) occurs; acceptance of

the concept that virtually any microorganism can cause a disease when the host is susceptible; and familiarity with clinical characteristics of opportunistic infections. The proper isolation of the microorganism via culture or in biopsy material is important.

The best preventive is to recognize the existence of opportunistic infections. Bacterial monitoring of patients with impaired defense mechanisms is advisable. Autoinfection is an important concept in opportunistic infection. The organisms isolated are usually of low pathogenicity and may be derived from the patient's own flora. And, all too often, these microorganisms are given the opportunity to take over because of the antibiotic-prescribing habits of physicians in special wards and units.

The concept of "reserve" drugs should be encouraged by staff agreement to restrict the administration of, for example, one or more anti-staphylococcal drugs. This antibiotic should be reserved only for a fulminating septicemia in order to reduce the incidence of infection with resistant staphylococci.

Patients with leukemia, lymphoma, uremia, severe burns, and diabetes mellitus are vulnerable to opportunistic infections because their defenses are lowered. The underlying disease must be adequately treated and the infection dealt with at the same time. Antibiotic sensitivity tests are of the utmost importance when an antimicrobial agent must be selected. Prophylactic antibiotics should be avoided, except in a few selected cases. ◀

T. R. Van Dellen, M.D.
Editor

Reference

1. Hillas Smith: "Opportunistic Infection." *British Medical Journal* (April 14) 1973, pgs. 107-110.

Clinics for Crippled Children Listed for December

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will conduct seventeen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Dec. 4 Belleville—St. Elizabeth's Hospital
- Dec. 4 Carmi—Carmi Township Hospital
- Dec. 5 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- Dec. 5 Hinsdale—Hinsdale Sanitarium
- Dec. 6 Lake County Cardiac—Victory Memorial Hospital
- Dec. 6 Sterling—Sterling Community Hospital
- Dec. 6 Litchfield—St. Francis Hospital
- Dec. 10 Peoria Cardiac—St. Francis Children's Hospital
- Dec. 11 Peoria—St. Francis Children's Hospital
- Dec. 11 East St. Louis—Christian Welfare Hospital
- Dec. 12 Champaign-Urbana—McKinley Hospital
- Dec. 13 Kankakee—St. Mary's Hospital
- Dec. 13 Bloomington—Mennonite Hospital
- Dec. 13 Springfield—St. John's Hospital
- Dec. 14 Chicago Heights Cardiac—St. James Hospital
- Dec. 17 Peoria Cardiac—St. Francis Children's Hospital
- Dec. 18 Peoria—St. Francis Children's Hospital
- Dec. 18 Rock Island—Moline Public Hospital
- Dec. 19 Aurora—St. Joseph Mercy Hospital
- Dec. 19 Chicago Heights General—St. James Hospital
- Dec. 19 Springfield Pediatric-Neurological—Diocesan Center
- Dec. 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Dec. 20 Rockford—Rockford Memorial Hospital
- Dec. 21 Evanston—St. Francis Hospital
- Dec. 21 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. ▶

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T₄) and Sodium Liothyronine (T₃). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T₄ and T₃ in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T₃ ¹³¹I resin sponge uptake, T₃ ¹³¹I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T₄ and T₃ is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

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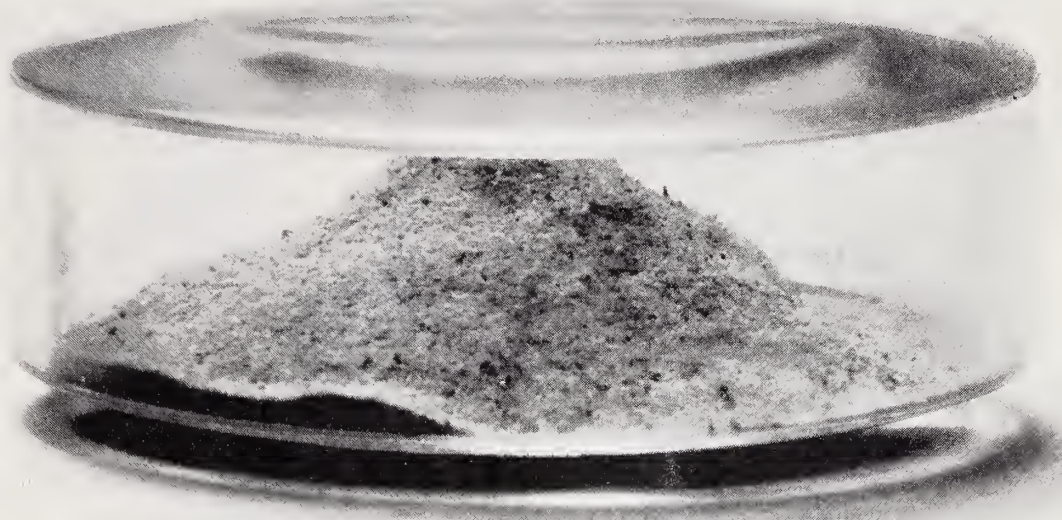
Then, Proloid is chemically and biologically assayed to assure consistent metabolic activity from batch to batch. The T_4 and T_3 content of every dose is blended for optimal thyroid replacement.

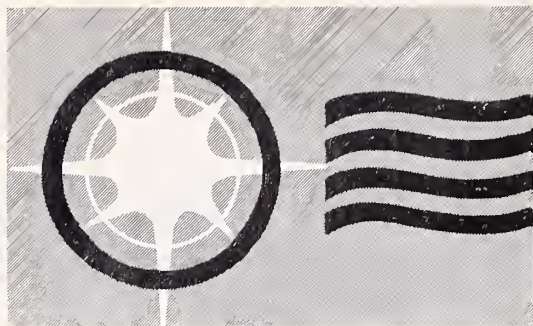
Important, too, is the fact that Proloid is invariably "fresh" when your patients take it. Under proper storage conditions, its potency will not diminish for at least four years.

All of which adds up to this: the potency of Proloid is constant...for more consistent results.

PROLOID® **(thyroglobulin)**

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that leaves
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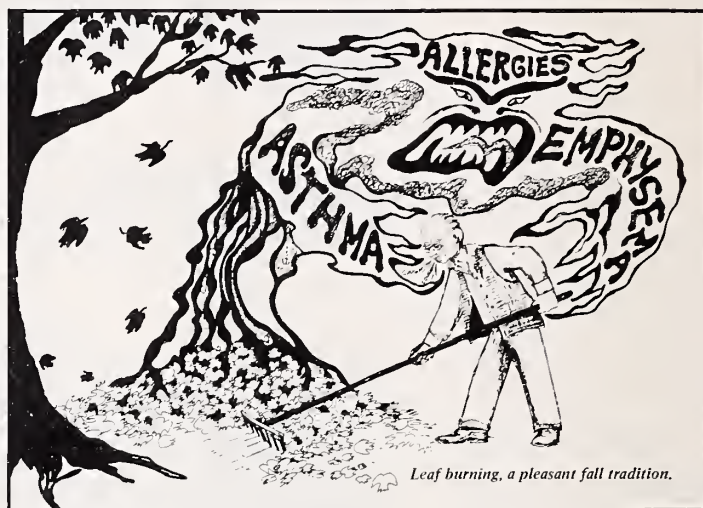
Dear Doctors:

A recent amendment to the Illinois Environment Protection Act was signed into law this Fall and prevents the Illinois Pollution Control Board from generally banning the burning of leaves throughout the State. It provides, however, that the Board may regulate leaf burning in areas of the State where, based on *generally accepted medical and biological evidence*, a health hazard can be shown to exist.

The Illinois Environmental Protection Agency has proposed a leaf burning regulation which attempts to meet this requirement by banning leaf burning in areas where federal health-related air quality standards (principally particulate levels) are being exceeded.

The greatest obstacle facing the Agency's proposed regulation concerns the health effects of leaf burning. Your expertise is critical in deciding whether, in fact, leaf burning presents a health hazard. Therefore, I ask that you answer the questions presented below and return the completed form to the Agency. The results will be summarized and provided to the Medical Society for presentation in a future publication and will be entered into the record at the Pollution Control Board's public hearings on the Agency's proposed leaf burning regulation.

Regarding the items presented below, the first and second questions are self-explanatory. Based on our experience, it appears that trying to quantify the health effects of leaf burning is extremely difficult since each individual has a different sen-



sitivity threshold. Therefore, the third question is intended to assist in determining whether the open burning of *any specific quantity* of leaves can cause adverse effects on the health of susceptible individuals who might reasonably be expected to be exposed to leaf burning situations.

The Illinois State Medical Society is commended for providing this opportunity to seek the professional opinion of all Illinois' doctors concerning an important environmental question. This is further evidence of the active involvement of the medical community in matters relating to the general public welfare.

Thank you for your participation and I look forward to your replies.

Respectfully,

Dr. John J. Roberts, Manager
Division of Air Pollution Control

Please answer and send to:

Illinois Environmental Protection Agency, 200 W. Washington St., Springfield, Illinois 62706

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Based on your experience, is it your medical or professional opinion that leaf burning is hazardous to health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you personally familiar with any case where leaf burning had adverse effects on the health of an individual? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Considering the population of susceptible individuals who might reasonably be expected to be exposed to leaf burning situations, is a typical, residential, fall leaf burning day likely to produce adverse health effects? | <input type="checkbox"/> | <input type="checkbox"/> |

Date

Name

City

Dear Editor:

I note with interest your editorial on "Why Go To Medical School" in the July, 1973 edition of the *Illinois Medical Journal*.

You state essentially the reasons for a young person to go to medical school, and then you have a second paragraph citing the reasons why they are deterred from medical training. An interesting point is the great difficulty encountered when a highly qualified applicant for medical school finds it almost impossible to get into a suitable school for continued training. An individual with a high scholastic average, high motivations, an eagerness to pursue the career of medicine, who has fulfilled all the requirements in training for a medical degree, is then faced with a wild scramble for admission to medical school with no certainty that such will be accomplished. It is my feeling that this in itself is a heart-breaking deterrent to the young individuals from whom the medical profession would derive its future members.

Sincerely,
Robert E. Field, M.D.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION
(Act of August 12, 1970: Section 3685. Title 39, United States Code)

1. Title of publication: IMJ Illinois Medical Journal
2. Date of Filing: September 25, 1973.
3. Frequency of issue: Monthly.
4. Location of known office of publication: 360 North Michigan Avenue, Chicago, Illinois 60601.
5. Location of the headquarters or general business offices of the publishers (Not printers): 360 North Michigan Avenue, Chicago, Illinois 60601.
6. Names and addresses of publisher, editor, and managing editor: Publisher: Illinois State Medical Society, 360 North Michigan Ave., Chicago, Illinois 60601. Editor: T. R. Van Dellen, M.D., 360 North Michigan Avenue, Chicago, Illinois 60601. Managing editor: Richard Ott, 360 North Michigan Avenue, Chicago, Illinois 60601.
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9. For Optional Completion by Publishers Mailing at the Regular Rates (Section 132.121, Postal Service Manual) 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U. S. C. 3626.
(Signature and title of editor, publisher, business manager, or owner) Richard A. Ott (Managing Editor).

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11. Extent and Nature of circulation.

	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total no. copies printed (Net press Run)	13,765	13,250
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales	200	200
2. Mail subscriptions	11,850	11,367
C. Total paid circulation	12,050	11,567
D. Free distribution by mail, carrier or other means		
1. Samples, complimentary, and other free copies	1,017	1,136
2. Copies distributed to news agents, but not sold	None	None
E. Total distribution (Sum of C and D)	13,067	12,703
F. Office use, left-over, unaccounted, spoiled after printing	698	547
G. TOTAL (Sum of E & F— should equal net press run shown in A)	13,765	13,250

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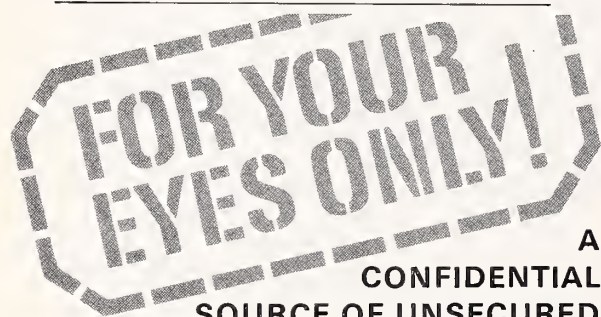
Richard A. Ott, Managing Editor

EKG of the Month

(Continued from page 512)

Answers: 1. A,C,D 2. A,B. The ECG shows an atrial tachycardia at a rate of 230 beats/minute and 3:1 AV block. The P waves are best seen in the limb leads I, II, III, avR, avL, and avF. Left ventricular hypertrophy is present based on the voltage of the QRS in leads V₂ and V₅. One premature beat is seen in the simultaneously recorded leads V₄, V₅ and V₆.

Whenever one encounters atrial tachycardia with A-V block, digitalis intoxication must be considered although other conditions may cause it. Therefore, withholding digitalis would be the first step in this patient's management. Correcting electrolyte imbalance by giving potassium chloride would be next. Apparently, the vomiting and diarrhea resulted in a large potassium loss and subsequent digitalis intoxication. In the presence of digitalis intoxication, increasing the digitalis or performing D.C. cardioversion could well cause a lethal arrhythmia. In this case restoration of electrolytes resulted in the spontaneous appearance of normal sinus rhythm. Digitalis was then safely resumed at a maintenance dosage. ◀



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An Unusual Presacral Tumor

(Continued from page 476)

in females makes one wonder if the frequency of pelvic and rectal examinations in women has been the reason for the numerical discrepancy, rather than some intrinsic anatomical factor.

The authors also question the origin of the patient's symptoms, going back to four years prior, when he had the spinal fusion. It permits the conjecture that, if myelography had been done at that time,⁴ possibly the presence of this meningocele would have become evident and would have directed alternative surgical approaches.

We conclude that the diagnostic quadrad, to rule out presacral tumors of this type, is described as follows: (Figure 6)

1. The "scimitar" sign in radiography of the sacrum.
2. Digital examination of the rectum and, in the female, both the vagina and rectum, for evidences of tumor.
3. Radiographic evidence of displacement of the rectum by colon X-ray.
4. Myelography.

The authors also suggest careful clinical examination in this anatomical region. We do not advocate the use of transrectal aspiration or biopsy procedures because of the possibility of bacterial meningitis.¹

Addendum

Since this case was reported in 1968 in Montreux, Switzerland, there have been approximately 40 additional cases reported in the literature. ▶

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Pancreatic Transplantation
For Diabetes Mellitus

(Continued from page 479)

of up to 1½ years with good pancreatic endocrine function. To date, none of these patients have exhibited progression of their retinopathy and several have demonstrated improved vision probably secondary to cessation of hemorrhage and resorption of old hemorrhages.

The more than four million diabetics who now presently run the risk of nephropathy or blindness cannot prevent these complications by careful management with exogenous insulin. Today, pancreatic transplantation provides them with a hope. Only by extensive and controlled clinical trials can we hope to determine the success of this procedure. ◀

Acknowledgements

The authors wish to thank Mrs. A. Baker and Dr. C. Serry for their assistance.

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Planning a Trip to Washington, D.C.?

If you are planning a trip to the nation's Capital city why not stop by and see your Congressmen. Let the ISMS headquarters make appointments for you with your Congressmen. Write or call: ISMS, Governmental Affairs, 360 N. Michigan Ave., Chicago, 60601; 312-782-1654.

View Box

(Continued from page 510)

Diagnosis: *Wegener's granulomatosis*—This entity is included within the group characterized by transient pulmonary shadows with eosinophilia (P.I.E. syndrome), although in fact the eosinophilia is not a prominent feature. The typical roentgenographic pattern in the lungs in Wegener's granulomatosis is that of rounded opacities, commonly sharply circumscribed, varying in size. They are frequently bilateral and widely distributed.

Cavitation occurs eventually in one third to one half of the cases. The cavities are thick-walled and have an irregular, rather shaggy inner lining. The paranasal sinuses frequently show considerable amount of sinus disease with destruction and in this case there is marked clouding of both maxillary antra with increased thickness of the turbinates and destruction of the medial wall of the right antrum. The usual triad of this disease is sinusitis, pulmonary findings and extensive renal involvement. ◀

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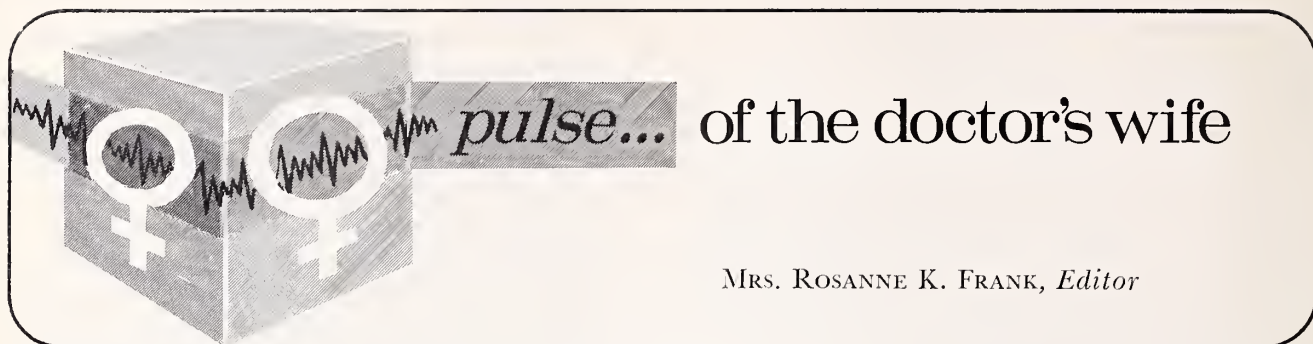
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MRS. ROSANNE K. FRANK, *Editor*

From the President's Desk:

Further reports from IDEA EXCHANGE gleaned at national convention that I want to pass on are:

Arizona: developed a mouth-to-mouth resuscitation sign. These were publicized nationally in Good Housekeeping magazine. Illinois has taken no action as yet to distribute some of these signs. These signs are so important during summer recreation and swimming season.

Texas: promoted a film on "operation identification"—how to mark valuable possessions with an electric engraver to discourage burglary. This was distributed through public libraries.

Wyoming: Handicapped and retarded persons got their attention. They *sold services* as well as donated gifts for a dinner-auction for raising money for a learning center and an "adoption plan" to care for a cottage family of eight handicapped persons.

Mrs. Robert (Bea) Hartman
WA/ISMS President

Auxiliary Members Attend Symposium



In last month's *Pulse* an article reported on the Communication Symposium attended by four members of the Woman's Auxiliary to the Illinois State Medical Society. In attendance at the symposium held in Champaign were, front row: Mrs. Robert Hartman, President and Mrs. Harlan Failor, Public Affairs Chairman. Back row: Mrs. William Schowengerdt, Rural Health Chairman and Mrs. Kenneth Furlong, Peoria, District #4 Councilor.

Something New: Is it Peoria County, District IV, which puts out the interesting newsy letter called "*House Call*"? At any rate it seems to be since the President was identified as *Nancy Sohlberg*. (Looks like you need to add information to your masthead, ladies).

It is an idea for other auxiliaries to follow because they have a chatty way of informing each other of momentous occasions in individual member's lives—the new baby, the new marriage, the grief. Along with all their community activities—and they seem to be an active group—they have found this way of keeping in touch on a more personal basis. It seems often too difficult to really "visit" with your fellow auxiliary members at meetings, and one never really gets acquainted with newest happenings in a meaningful way.

P.S. They also seem to have time for partying with their husbands—not a bad idea to break the doldrums of a hard midwestern winter!

* * *

AMA-ERF: It is that season again—time for you to keep in close touch with your AMA-ERF chairman in the individual auxiliaries. Mrs. Earl Klaren, Libertyville, (state committee AMA-ERF Chairman) has sent to the membership new catalogs of "goodies" available for holiday giving. This also is the time to replenish your personal note and stationary supplies. In addition, bookplates are being offered this year.

Mrs. Klaren's goal is "A MILLION FOR A MILLION"—and this is possible if each county brings in only a \$10 per capita donation!

Then there is the new AMA cookbook which sells for \$5.00 per book. Credits go to AMA-ERF for your auxiliary. This cookbook contains 500 physician-tasted recipes from the kitchens of the wives of the AMA Board of Trustees.

* * *

Food for Thought: If you missed the report on Dr. Harry Schwartz's talk at the national convention in New York I commend to you the following as food for thought: "I suggest a tri-partite approach: 1. study the value of American medicine, be conscious of its weaknesses and improve human relations; 2. more economical medical care, immunization and preventive medicine should be pushed; and 3. know the facts of medicine and *the ladies should step into the socio-economic field.*"

He went on to say, "that there is no immortality in medicine, not even in Sweden. Real problems and real faults do exist and criticisms include: 1. a shortage of physicians and facilities in sections of the country; 2. a demand for afford-

able medical care and kidney dialysis as a costly example; and 3. rude, thoughtless, and greedy individuals."

These remarks should help us identify some future goals for ourselves as physician's wives, and auxiliary members.

* * *

In Memorium

We are saddened to know of the death of Betty Adams Pitcher. Mrs. Pitcher, age 76, had no immediate survivors; so perhaps the Woman's Auxiliary can act in lieu of family and remember her kindness in their prayers. It was through her generosity that makes it possible for the Health Education Conference in Chicago this coming February. At last year's WA/ISMS annual Meeting, Mrs. Pitcher so graciously presented the Auxiliary with a check for \$1,000. It gave her joy to give and we shall be using her money wisely.

* * *

Message From the Editor:

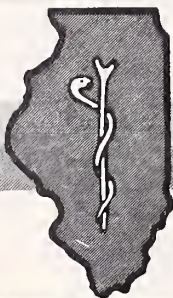
As your editor I am pleased to report that I shall have the opportunity of speaking on the Problems of the Doctor's Wife, at a seminar in Williamsburg, Virginia in mid-November. It is the 20th annual meeting of the Academy of Psychosomatic Medicine.

I would appreciate having letters from any of the members who feel that they can contribute to my "list of problems" which are unique to us by virtue of being spouses of physicians. This is a golden opportunity for airing!

Rosanne Frank, Editor



Dr. and Mrs. Irving (Rosanne) Frank converse on subjects of interest in the medical and nursing field. Dr. and Mrs. Frank have been authors of numerous articles; their latest article "Problems of Sexuality" appeared in the July/August, 1973, issue of *Psychosomatics*.



report

Illinois Society
American Association of Medical Assistants

Doctor, How Does Your Medical Assistant Rate?

Is your medical assistant just adequate or superior? A good medical assistant brings to her job a sense of adventure, joy and compassion, as well as office skills seldom found in any other profession. One must be "a certain breed of cat" to fit in and be happy in a medical office. If learning stops when one lands a job, then the employee has no business in the medical field.

Our organization gives motivation to medical assistants who are interested in doing a better job. It gives its members a sense of their own worth and the association of likeminded people with whom to share. It develops a good relationship between the physician and his employee which is of great benefit to his practice because the organization promotes efficiency, loyalty and knowledge of ways in which the office can be made to run more smoothly. Problems, of which there are many in a medical office, are shared, discussed and ways of overcoming them are devised. It is a wonderful feeling to be able to call another medical office when help is needed in procedures such as

billing, information concerning a patient under treatment, methods of better assisting the physician, or any number of problems that arise in a medical office, and find on the other end of the line an assistant with whom one has worked on projects or classes through the organization. Communication is much easier with someone one knows. Understanding is heightened and problems more easily resolved, all of which is an added benefit to the assistant, the patient and the physician.

Doctor, you are required to upgrade your knowledge and skills by a program of continuing education. How does your medical assistant upgrade her knowledge and skills? The American Association of Medical Assistants has a constant program in continuing education, and without continuing training, the medical assistant in today's sophisticated medical office would be without the ability to communicate with others in the field and her identity would soon be lost. (*The California Medical Assistant—Special Edition*)

* * *

Message for Registered Nurses and Medical Assistants . . .

What does the American Association of Medical Assistants, Inc., have to offer you as a Registered Nurse, or to you, Doctor, as the employer of an R.N. in your office?

If as an R.N. you have found that working in a hospital is not exactly your "cup of tea," as some of us have found, and if you have found that you prefer the working conditions and desirable working hours in a physician's office or possibly as an Industrial Plant Nurse, then you may consider yourself a good candidate for membership in the AAMA.

Ordinarily this type of nurse has had some business education as well as nursing education and finds herself in management rather than full-time nursing. The AAMA offers continuing education in business methods in addition to keeping the R.N. aware of new advances in medicine providing a more efficient office operation.

One benefit of membership in AAMA is the opportunity to meet and know assistants in other offices. We find a referral, appointment request, etc., is expedited if one personally knows the person at the other end of the tele-

phone line. Improved patient care results.

Tri-level dues are minimal as compared with the ANA, creating no financial hardship for the R.N. who wishes to maintain membership in both organization. From each organization she receives educational journals, is offered the best possible insurance coverage at minimal cost (hospital-medical, retirement and life insurance), and is given an opportunity to take advantage of these benefits with some choice as to which plans she prefers.

It is our sincere hope that you will give a favorable consideration to a professional organization which promises to provide you an even more knowledgeable "all-around" office nurse; and your nurse, with unlimited opportunities to advance educationally with her peer group of office Registered Nurses. (*The California Medical Assistant—Special Edition*)

For further information, write: (Mrs.) Norma R. Domanic, President, Illinois Society, AAMA, Inc., 150 Ash Street, New Lennox, IL 60451.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington, 61701, 309-828-6051. (1)

BLUE ISLAND: Gastroenterologist, Ophthalmologists and Otolaryngologist urgently needed in this south suburban community. City of approx. 20,000, but hospital and clinic serving approx. 250,000. Pronger-Smith Clinic, old, well-established clinic in beautiful new building. Generous starting salary. Contact: Gerald A. Caress, 2320 W. High St., Blue Island, 60406, 312-388-5500. (2)

BRADLEY: Looking for replacement (male or female) in my general practice. Fully equipped including competent personnel. Open staff hospital privileges. Leaving for health reasons. Trade area of 90,000, 60 miles south of Chicago. Write Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CHICAGO: Young multispecialty group with 4 locations. 24 physicians at present. Need Family Physicians or General Internists. Hospital appointments assured. Financial reward commensurate with effort. Opportunity to grow with group. Contact: Dr. Arthur Kunis, 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (2)

CHICAGO: Opening in welfare clinic, south side; no hospital work. Guaranteed salary. Good opportunity to work into a part-ownership. Contact: Robert C. Parro, Chicago Medical Center, Inc., 657 W. 79th St., Chicago, 60620, 312-994-0100. (11)

CHICAGO: The Cancer Prevention Center, a multi-phasic health screening facility, seeks internists, surgeons, gynecologists for its comprehensive health examinations. Employment is part time. Interested physicians are invited to visit and apply. Please contact the office of Angelo P. Creticos, M.D., 33 W. Huron, Chicago, 60610, 312-944-4371. (11)

CHICAGO: Openings for Medical Specialists and General Practitioners. We are seeking clinicians and supervisors to provide comprehensive health care to City residents through network of Neighborhood Health Centers. Competitive salaries, complete fringe benefits. Contact Mr. Gerald O'Sullivan, Personnel Office, Board of Health, Civic Center, Chicago, 60602, 312-744-3805. (3)

CHICAGO: Internist; an insurance company has an opening for the position of staff physician in its medical department. Full-time, fringe benefits, salary negotiable, office population. Contact: Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CHICAGO: Multispecialty group need two full-time Pediatricians. Hospital appointments assured. Financial reward commensurate with effort and background. Opportunity to grow with group. Contact: R. L. Kelsey, M.D., 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (3)

CLINTON: General Practitioners needed for rural community. Population 8,000. 50 bed JCAH hospital. Located 25 miles from Bloomington and Decatur and 40 miles from Springfield. This community offers good schools and educational opportunities, recreational areas, and shopping areas within a short distance. Medical Staff needs your help. Contact: Dr. Charles Ramey, 215 East Main Street, Clinton, 61727, 217-935-2191. (12)

DANVILLE: Population 45,000; Drawing area more than 100,000. Primary need in General Practice-Family Physician, however many specialties also required. Excellent hospital facilities; many specialties well represented. Fine community, affiliation with the University of Illinois Medical School available. Office space available. Contact: W. N. McCormack, M.D., 812 N. Logan Avenue, Danville, 61832, 217-443-5362. (11)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

GALENA: Pop. 4,000. Family/General Practitioner needed to join three other FPs. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 80,000. Historical community offers very good school systems, numerous churches, and outstanding recreational facilities. Contact: Wilbur E. Johnson, M.D., 300 Summit Street, Galena, 61036, 815-777-0900. (11)

GENEVA: GP's or Internists, outstanding area with unlimited practice opportunities needs you to grow with us. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "New England" background—and all only 35 miles from the cultural and medical education advantages of Chicago. Contact: Peter G. Gilbert, M.D., c/o Community Hospital, Geneva, 60134, 312-232-0771. (2)

GENEVA: Family Practice physician needed to join group of three family practitioners in unique New England-like town of 9,000, 40 miles west of Chicago. Service area of 50,000. New office eight blocks from excellent 130 bed hospital. No investment, guaranteed base, full partnership expected within one year. Liberal time off. Rotating call schedule—work one week-end per month. Excellent schools located in beautiful Fox River Valley. Contact: Drs. Bordenave, Barnes and Temple, 1665 South Street, Geneva, 60134, 312-232-2200. (3)

GENERAL MEDICAL SERVICES, LTD ("Physicians-On-Call"): Emergency room, house call, clinic work available in 16 hospitals and clinics throughout State: Chicago, Peoria, Dixon, Bloomington, etc. Full-time or part-time work available. Contact G. M. Gnertner, M.D., 153 West Lake Street, Bloomingdale, 60108, 312-627-3404. (12)

HARRISBURG: 4 General Practitioners, Cardiologist, OB-GYN and Ophthalmologist wanted. Population of 10,000. Modern hospital to practice in. Please contact Carl L. England, Jr., Administrator, Doctors Hospital, Harrisburg, 618-253-7671. (11)

HOOPESTON: Organizing medical group, looking for obstetrician, internist, and general practitioner. Trouble free community of 8,000; stable economy, drawing area of 25,000. Well established practice. Contact: E. P. Kosyak, M.D., 847 E. Orange St., Hoopeston, 60942, 217-283-5557. (12)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (11)

MACON: Thriving community of 1600. Five of seven nearby towns without resident physician. Adequate unfurnished building available. Assistance given to become established. Located 8 miles south of Decatur (two first-class hospitals). Excellent schools. Five churches. Contact: Olive Johns, 250 W. Ruby St., Macon, 62544, 217-764-3483. (11)

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute

drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265. (11)

OTTAWA: Population 20,000. 75 minutes from Chicago loop via Interstates. Completely equipped ground floor physicians office with adjacent parking space. Enjoy good living and recreation as well as congenial professional relationships. Entirely new 125 bed hospital due to open this October. No traffic, no smog, just excellent family living. Contact: E. R. Maierhofer, M.D., 226 W. Madison St., Ottawa, 61350, 815-434-7418. (12)

ROCKFORD: Internist, Board Eligible, to join two busy Internists in partnership. Excellent hospital facilities with medical school appointment available. A metropolitan city (2nd largest in state) which offers "small town living". Salary negotiable. Contact: Thomas R. Glatter, M.D., 5670 E. State St., Rockford, 61108, 815-398-4040. (2)

SOUTHERN ILLINOIS: Southernmost Illinois Health Care Planning Council—Represents 76,000 population in southern Illinois, with 4 hospitals in the area. Picturest southern Illinois is proud of its recreational facilities, schools and Southern Illinois University within commuting distance. Office space and housing available. Contact: Ray Oxford, Planning Director, 421 N. Blanche Street, Mounds, 62964, 618-745-6528. (12)

STREATOR: Family Physician needed to join 10 man (2 family physicians) multispecialty group in community of 20,000, with new clinic building across from hospital, excellent practicing facilities for energetic physician, full insurance benefits, guaranteed income; teaching opportunities. Contact: C. T. Hawkins, M.D., Streator Medical Clinic, S.C., 104 Sixth St., Streator, 61364, 815-672-0511. (12)

ANNOUNCING . . .

The 3rd Annual Doctor's Job Fair

9:00 a.m. - 4:00 p.m.

December 2, 1973

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Openings are available for physicians who qualify for an Illinois License with approved training in Psychiatry, Internal Medicine or General Medicine.

Salaries for Illinois-licensed physicians range from \$26,000 to \$44,600 depending upon professional qualifications, experience and capability of assuming increasing professional responsibilities, i.e., Board Certified or Eligible Physician, commencing salary \$30,732.

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Interested doctors should write to Mr. Bernard McLaughlin, Medical Staff Employment Administrator, Illinois Department of Mental Health, 160 North LaSalle Street, Chicago, IL. 60601 or call collect—area code 312, 793-2748 or 2749, hours 9 a.m. to 4:30 p.m.

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SPECIALTY REVIEW IN THORACIC SURGERY, December 10
SPECIALTY REVIEW IN PEDIATRICS, March 25
NEUROLOGY, Part I, Basic, One Week, March 25
SURGERY OF TRAUMA, 4 Days, November 26
SYMPOSIUM ON SHOCK, 2 Days, November 30
MANAGEMENT OF SPECIAL SURGICAL PROBLEMS, Feb. 4
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Mar. 12
MANAGEMENT OF COMPLICATIONS IN SURGERY, March 11
BLOOD VESSEL SURGERY, One Week, March 25
ADVANCES IN OBSTETRICS & GYNECOLOGY, One Week, Nov. 26
BASIC OBSTETRICS, One Week, March 25
BASIC GYNECOLOGY, One Week, April 1
ADVANCES IN INTERNAL MEDICINE, One Week, Nov. 26
RECENT ADVANCES IN PSYCHIATRY, One Week, Dec. 3
NEUROPATHOLOGY REVIEW, One Week, April 1
BASIC ELECTROCARDIOGRAPHY, One Week, March 4
BASIC INTERNAL MEDICINE, One Week, March 18
GENERAL PEDIATRICS, One Week, November 26

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Obituaries

***Argent, Oscar**, Chicago, died August 31, at the age of 93. His work in eye surgery received international recognition. He received his medical degree from the University of Illinois in 1909. During the 1920's he took post-graduate courses in the clinics of England, France, Germany, Belgium, Switzerland, Austria, Hungary, Italy and Spain. In 1927 he performed almost 2,000 eye operations while doing research work with Sir Henry Holland in India. During 1928 when he was appointed Dean of the Chicago Eye, Ear, Nose and Throat College, the out patient department was build up to almost 52,000 patients a year. In 1930, King Alphonso, Spain, presented him a gold medal and certificate of honor for his work.

***Dill, Loran**, Chicago, died August 26, at the age of 74. He graduated in 1929 from Northwestern University.

***Garner, Harry H.**, Chicago, died October 2, at the age of 63. Dr. Garner was Professor and Chairman of the Department of Psychiatry and Behavioral Sciences at the Chicago Medical School and Mount Sinai Hospital Medical Center. He was an internationally recognized authority and pioneer on short term psychotherapy and the problem-solving technique. Dr. Garner was author of more

than 100 publications and three books. He graduated from Northwestern University Medical School in 1934.

***Kersey, George Thomas**, Chicago, died August 25, at the age of 67. He graduated in 1934 from the University of Illinois.

***Leslie, Eleanor**, Glenview, died September 2, at the age of 79. She graduated from Johns Hopkins University in 1924.

***Lovius, Clairvoix**, Chicago, died September 10, at the age of 40. He graduated in 1963 from the University of Haiti.

***Perry, Robert Boyd**, Lincoln, died September 28, at the age of 81. He graduated in 1930 from the University of Colorado.

***Seinfeld, Samuel G.**, died August 28, at the age of 73. He graduated from the University of Illinois in 1927.

***Sperling, Arnold**, Chicago Ridge, died September 12, at the age of 82. He had been a physician for more than 50 years. He graduated from Bratislava, Czechoslovakia, in 1920. ◀

*Denotes member of ISMS

**Denotes member of 50-year Club and ISMS

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In the absence of a local affiliated Foundation for Medical Care, I the undersigned, hereby apply for participating membership in the ILLINOIS FOUNDATION FOR MEDICAL CARE. I certify that I am a licensed physician qualified to practice medicine in all its branches, and eligible for membership in the Illinois State Medical Society.

If accepted as a participating member, I agree to support and adhere to the By-Laws of this Corporation and be bound by the established principles of medical ethics. I agree to cooperate with duly established peer review mechanisms and abide by their recommendations, subject to the right of appeal.

I understand that all programs sponsored by this Corporation will utilize the fee concept current in my local medical community. I reserve the right not to participate in specific Corporation programs if I so notify the Corporation of my intentions in writing.

I recognize that this membership will be automatically renewed annually unless terminated by written notice from either party.

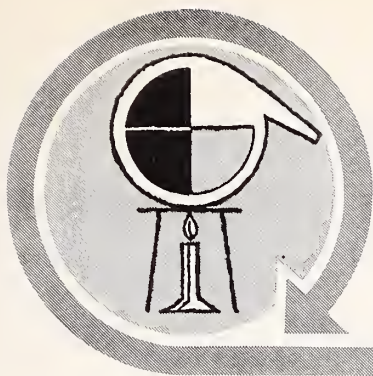
Date: _____

(Signature) M.D.

(Please Print Name) M.D.

(Street Address)

(City) (State) (Zip Code)



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

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The following new drugs have been marketed:

SINGLE CHEMICAL

CHOLEBRINE Oral Cholecystographic Agent R

Manufacturer: Mallinckrodt Pharmaceuticals

Nonproprietary Name: Iocetamic Acid

Indications: Radiographic visualization of the gallbladder.

Contraindications: Advanced hepatorenal disease, severe renal impairment, and patients allergic to iocetamic acid. Do not use in children under 12 years of age.

Precautions: Use with caution in patients with cardiovascular disorders, particularly coronary artery disease.

Dosage: Adults—single dose of 3 to 4.5 gm.

Supplied: Tablets, 750 mg.

DUPLICATE SINGLE DRUGS

CALMURID HC 1% Corticoid Local R

Manufacturer: Pharmacia Laboratories, Inc.

Nonproprietary Name: Hydrocortisone

Indications: Relief of inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications: Those usual for corticosteroids; not intended for ophthalmic use.

Precaution: If irritation develops discontinue use.

Dosage: Apply to affected area three or four times daily.

Supplied: Tubes, 30 gm., 1%.

VITAMIN E CAPSULES Vitamin o.t.c.

Manufacturer: Parke, Davis & Company

Nonproprietary Name: Alpha Tocopherol
(Alpha Tocopheryl Acetate)

Indications: Vitamin E deficiencies

Dosage: Prophylactic—from 5 to 30 International Units
Therapeutic—According patient's requirements

Supplied: Capsules, 100 I.U.

COMBINATION PRODUCTS

B-C-BID Vitamins o.t.c.

Manufacturer: Geriatric Pharmaceutical Corporation

Composition: Vitamin B-1 15 mg.

Vitamin B-2 10 mg.

Vitamin B-6 5 mg.

Niacinamide 50 mg.

Calcium Pantothenate 10 mg.

Vitamin C 300 mg.

Vitamin B-12 5 mcg.

Indications: Vitamin B and C deficiencies

Dosage: One capsule b.i.d.

Supplied: Sustained release capsules

RHULIGEL Antipruritic o.t.c.

Manufacturer: Lederle Laboratories

Composition: Benzyl Alcohol 2%

Menthol 0.3%

Camphor 0.3%

Alcohol 31%

Indications: For temporary relief of itching from ivy and oak poisoning, nonpoisonous insect bites and mild sunburn.

Administration: Apply to affected area b.i.d. or t.i.d. or as required for relief.

Supplied: Tubes, 2 oz.

NEW DOSAGE FORMS

HERPLEX OPHTHALMIC OINTMENT Antivirals R

Manufacturer: Allergan Pharmaceuticals, Inc.

Nonproprietary Name: Idoxuridine

Indications: Keratitis caused by the virus of herpes simplex.

Precautions: Concurrent use of corticosteroids contraindicated.

Dosage: Place small amount of ointment inside conjunctival sac five times daily at 4 hrs. interval.

Supplied: Tube, idoxuridine 0.5%

KEFLEX FOR ORAL SUSPENSION Antibiotic R

Manufacturer: Eli Lilly & Company

Nonproprietary Name: Cephalexin Monohydrate

Indications: Infections caused by susceptible organisms in respiratory, genito-urinary tract and skin and soft tissue disorders.

Contraindications: Known allergy to cephalosporins and penicillins.

Dosage: See package insert

Supplied: Bottles 100 cc.; 250 mg. cephalexin/5 cc.

NEW USE

INDERAL Adrenergic Blocking Agent R

Manufacturer: Ayerst Laboratories

Nonproprietary Name: Propranolol HCl

Indications: Angina pectoris due to coronary atherosclerosis.

Contraindications: See package insert

Dosage: See package insert

Supplied: Tablets, 10 & 40 mg.

SYMMETREL Muscle Relaxant, Parkinsonism R

Manufacturer: Endo Laboratories, Inc.

Nonproprietary Name: Amantadine HCl

Indications: Idiopathic Parkinson's disease, postencephalitic Parkinsonism, and symptomatic Parkinsonism.

Contraindications: Hypersensitivity to the drug

Dosage: If given alone—100 mg. b.i.d. For combination with other drugs see package insert.

Supplied: Capsules, 100 mg. ◀

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

PHYSICIANS WHO ARE INTERESTED in providing **MEDICAL SERVICES** to business organizations on a **PART-TIME** or **FULL-TIME BASIS** may obtain a copy of the Employment Referral Service Bulletin published monthly by the Industrial Medical Association. Openings for positions throughout the country are listed therein. For a **FREE COPY**, write the Industrial Medical Association, Employment Referral Service, 150 North Wacker Drive, Chicago, Illinois 60606.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

GASTROENTEROLOGIST WANTED for beautiful multi-specialty clinic in south suburbs of Chicago. Must be licensed in Illinois. Write: Mr. G. A. Caress, 2320 W. High St., Blue Island, Ill. 60406 or Call: (312) 388-5500.

WANTED: PHYSICIANS, SPECIALISTS OR GENERALISTS, who want to discover Ozaukee County, Wisconsin. A beautiful blend, rural agricultural with many cities and villages growing and progressing but still preserving an Early American charm. This prime recreation area bordering Lake Michigan has a modern progressive hospital at Port Washington serving the population of 55,000 but short the necessary link—Physicians. Contact George Seidenstricker, St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone: 414-284-5511.

INTERNISTS: Prefer Bd. Cert. or Bd. eligible, opportunity for private, group practice. Offices, hospital based, newly constructed, plus renovated 200 bed, fully accredited acute care community hospital. Low overhead. Contact Administrator, Loretto Hospital, 645 S. Central Ave., Chicago, Ill. 60644. (312) 626-4300.

SHELL LAKE CLINIC, LTD., Shell Lake, Wisconsin, expanding to seven man group. Three family physicians and one surgeon desire additional **TWO FAMILY PHYSICIANS and ONE INTERNIST**. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call (715) 468-2711 or write to Clinic Manager, Darrell Bailey.

FAMILY PRACTICE OPENING—January, 1974 in two man office. Cashmere, Washington, outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Washington 98815.

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Positions & Practice Opportunities (Con't)

ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS—Welfare area in need of physicians. Please contact: Mr. Robert Fields 312-236-2555.

OPENING for PHYSICIAN in ADMISSIONS and OUTPATIENT CLINIC. Active 530-bed teaching hospital affiliated with Northwestern McGaw Medical Center. Current license in any State acceptable. Beginning salary depending on qualifications. Excellent vacation, insurance and retirement benefits. Contact: H. M. Daskal, M.D., Veterans Administration Research Hospital, 333 East Huron Street, Chicago, Illinois 60611, or phone (312) 664-6600. **AN EQUAL OPPORTUNITY EMPLOYER.**

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INTERNIST or GENERAL PRACTITIONER: An insurance company has an opening for the position of Staff Physician in its Medical Department in Chicago. Full time. Fringe benefits. Salary negotiable. Office population. Send curriculum vitae to Box 823, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FOR SALE, LEASE OR RENT

PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone 815-725-1188.

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

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Office Space Available, **4010 W. MADISON STREET, CHICAGO, ILL.** 1-2-3 Rm. Suites or larger, in first class fireproof heated building. Good cleaning service. Automatic elevators. Plenty of business here for Doctors or Dentists etc. Immed. Poss. Contact: R. M. Ryan Realtor Agent, phone: (312) 243-2727 or apply Office of Building.

IDEAL LOCATION FOR DOCTOR in River Forest, Illinois. **HOME FOR SALE:** Red Brick Col., 4 Br., 2 1/2 Bths., Large Lv. & Dn. Rms., new Kitchen, pan. Library, Solarium, paneled Rec. Rm., 3 Fireplaces, 15 closets, Central Air. Lot 70x190. Nr. schools, shopping, transportation. Within 20 minutes to ST. ANNE, WESTLAKE, LOYOLA, GOTTLEIB, and NORTHLAKE HOSPITALS. Low 90's. By appt. only. Phone (312) FO 9-8435.

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FOR RENT: Beautiful suite available in medical center. Nice mid-western city located near Chicago. 1,000 square feet. Ideal for any medical practice. West Side Professional Building. 1795 Grandstand Place, Elgin, Ill. 60120. 312-695-8618.

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463	American National Bank	454-455	Pharmaceutical Manufacturers Association
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458	Chicago Title and Trust	443	U.S. Navy/ <i>Navy Medical Corps</i>
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Illinois Medical Journal

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DECEMBER, 1973 · VOL. 144 / NO. 6

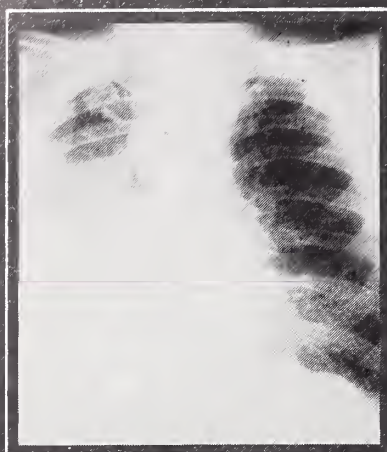
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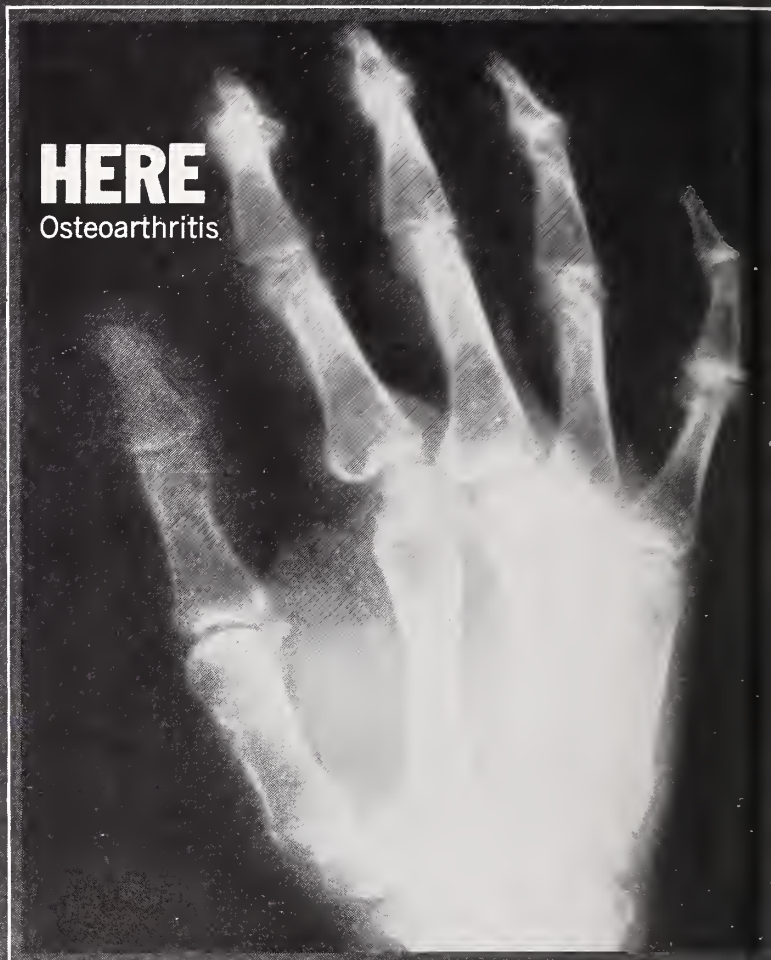


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BLUE SHIELD REPORT



FOR *Illinois Physicians*

Omission of Social Security Number Delays Blue Shield Payments of State of Illinois Employee Claims

Omission of the employee's Social Security number from the Blue Shield Physician's Service Report form is causing a relatively high volume of delays in the payment of claims being processed for members enrolled in the State of Illinois Group Insurance Program.

Although the absence of the Social Security number on the claim is by far the most frequent reason for payment delays, a sizeable number of claims are being received in our Chicago and Springfield special payment centers with the Illinois Group Number 42500 or employee's code number used erroneously in the box where the Social Security number should be listed—normally the box reserved for the Subscriber Number to the right of the Illinois Group Number 42500. (See reduced portion of Service Report and problem area encircled below.)

When the Social Security number is omitted, or another number is used in its place the Blue Shield member cannot be identified as an eligible member of the State of Illinois employee program.

A request for additional information must then be made to complete the claim. Until this important information is received and the claim completed, payment is delayed.

Because a claim filed without the Social Security number will result in a payment delay, it may be helpful to refer to the employee's special Blue Cross-Blue Shield identification card when a physician's service is furnished.

Although the card contains all the essential items for employee identification, the **two most important numbers** on the card—for claims purposes—that must be used on the Blue Shield Physician's Service Report are the Group Number 42500 and the employee's Social Security number.

Your assistance in reviewing State of Illinois employee claims for completeness, particularly in respect to the use of the employee's Social Security number on the claims before submitting them to our Chicago or Springfield offices will help us to speed payments of program benefits.

COMPLETE INFORMATION NEEDED

PHYSICIAN'S SERVICE REPORT

TO SPEED BLUE SHIELD PAYMENTS
TO YOU, MAIL TO →



BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE
233 N. MICHIGAN AVE., CHICAGO, ILLINOIS 60601
661-4200

Patient's Name	John Doe	Age	28	Sex	M
	(Type or Print)				
	John Doe				
Subscriber's Name and Address	Name	42500 344-16-7571			
	1800 Evergreen Plaza	GROUP NO. SUBSCRIBER NO.			
	Street				
	West Chicago Heights, Illinois 60411				
	City, State & Zip Code				

Is This a Workman's Compensation Case?
Yes ☐ No ☐ Possibly ☐

1. ☐ Hospital Inpatient

2. ☐ Hospital Outpatient

THE "TROUBLE SPOT": Most delays in payment of claims for the State of Illinois Group Insurance programs are caused by the omission of

the employee's Social Security number, shown encircled above, in box to right of Group Number. Please include only this number.

ASK BLUE SHIELD ... ABOUT MEDICARE

December Time Limit Near For Filing Part B Medicare Claims

The time limit established by the Social Security Administration for filing Part B Medicare claims for services furnished in the last three months of 1971 and first nine months of 1972 is December 31, 1973. Since that date is close-by, we recommend that you file claims for services you furnished in those periods before the time limit expires.

All claims for services furnished prior to October 1 of one year must be submitted by December 31 of the following year. Services and supplies provided during the last three months of a calendar year are considered to have been furnished in the following year.

Therefore, charges applied to the deductible during the months of October, November and December of one year may be applied to the deductible for the following year. Below are some examples of the time limits:

For Services Rendered from
October 1, 1971-September 30, 1972
October 1, 1972-September 30, 1973

Claims Must Be Filed by
December 31, 1973
December 31, 1974

When a physician accepts an assignment within the allowed time limits but delays filing the claim beyond the time limit allowed, special provisions apply. If the claim is \$300.00 or less, the physician may bill the patient for only 20 percent of the total amount of the claim and not for any charges that would have been applied to the Part B deductible.

When the charge is more than \$300.00 the Part B carrier will assume the deductible has been met, determine the deductible charges and advise the physician and patient that it is the patient's responsibility to pay the remaining 20 percent of the reasonable charge.

Coverage of Health Care In Pregnancy of the Disabled Under 65

Among the amendments to Medicare in 1972 is a provision that extends coverage to disabled beneficiaries under age 65. Reasonable and necessary health care services associated with pregnancy for the disabled under 65 are now reimbursable under the program.

Such services are reimbursable under Part B Medicare on the basis that because pregnancy is a condition which is sufficiently at variance with the usual state of health it is appropriate for a pregnant woman to seek medical care. Because of the possibility of illness or injury which accompanies the condition, medical supervision is required throughout pregnancy and for a period thereafter.

Medical management is considered appropriate beginning with the diagnosis of the condition, continuing through delivery and ending after the necessary postnatal care. In the event of termination of the pregnancy, regardless of whether it is spontaneous or induced for therapeutic or elective reasons, the need for skilled medical services is as important as in those cases carried to full term.

After the infant is delivered, items and services furnished to the infant are not covered nor reimbursable under the program.

Conditions for Coverage of Sterilization

A recent revision to Medicare coverage allows payments to be made under Part B benefits for sterilization only when it is a necessary part of the treatment of an illness or injury, such as the removal of a uterus because of a tumor, removal of a diseased ovary (bilateral oophorectomy) or bilateral orchidectomy in a case of cancer of the prostate. Sterilization performed for nontherapeutic purposes, such as vasectomy, is not covered.

SSA Certifies New Laboratories

The following laboratories have been certified for participation in the Medicare program by the Social Security Administration:

Lancet Laboratories
3166 Des Plaines Boulevard
Des Plaines, Illinois 60016
Provider Number 14-8264
Effective Date: October 12, 1973

E. B. Laboratory Services
3359 West Chicago Avenue
Chicago, Illinois 60651
Provider Number 14-8263
Effective Date: September 20, 1973



Placidyl® (ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of Insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug, such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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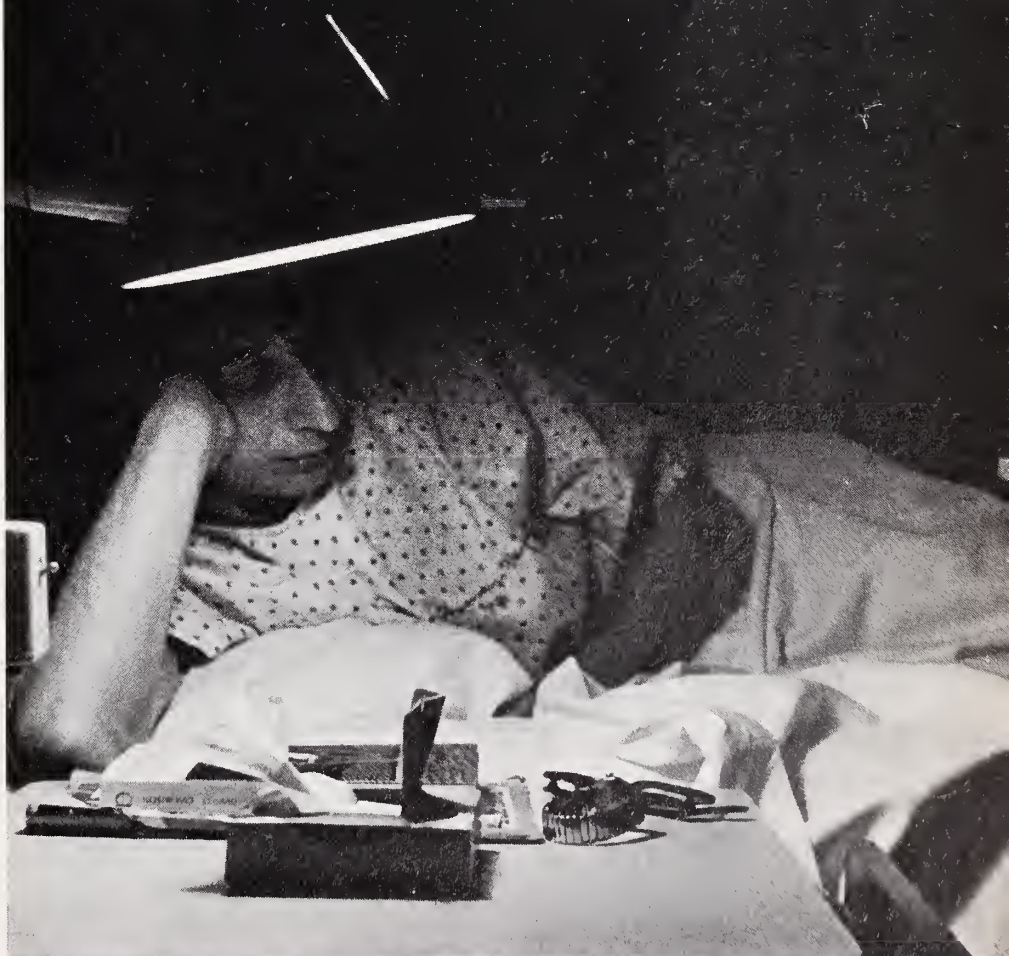
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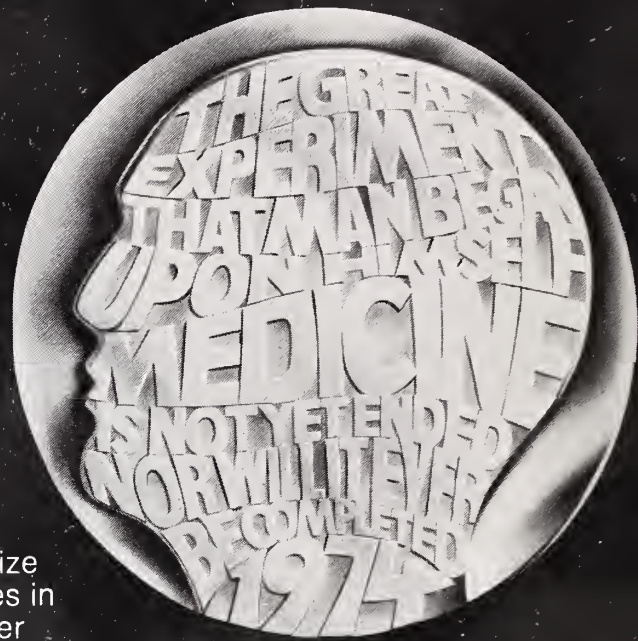
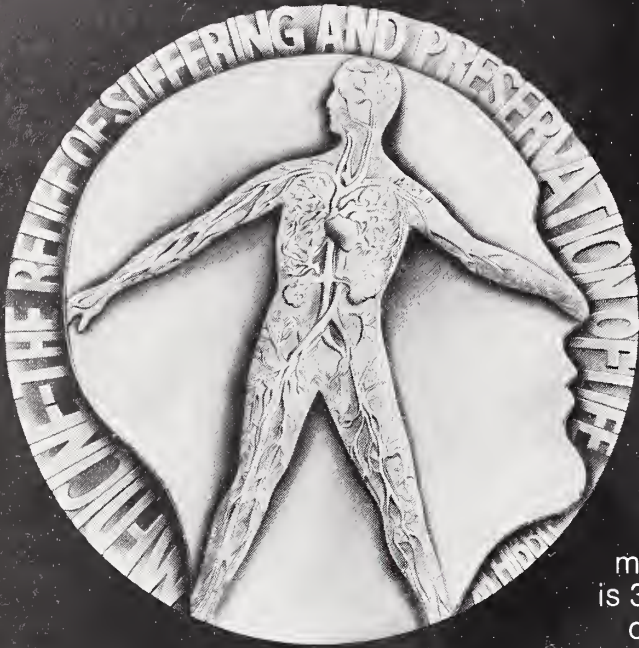


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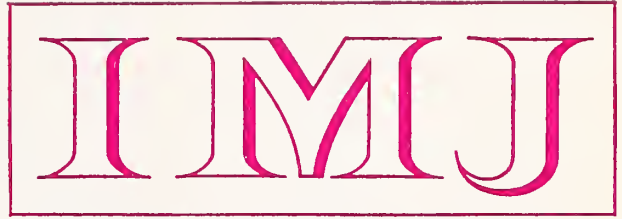
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Illinois Medical Journal

DECEMBER, 1973

Vol. 144, No. 6

CONTENTS

- 552** Abstracts of the Board of Trustees Meeting
611 Accumulative Index, Vol. 144
-

Special Article

- 555** Foreign Trained Physicians in Illinois
Kong Meng Tan, M.D.
-

Clinical Articles

- 560** Headache Associated with Low Spinal Fluid Pressure Syndrome
Seymour Diamond, M.D. and Bernard J. Baltes, M.D., Ph.D.
- 562** The Treatment of Accessible Malignancy Tumors by Irradiation
J. Ernest Breed, M.D.
- 564** Allergic Aspergillosis in a Family
Vicharn Vithayasai, M.D., John S. Hyde, M.D. and Lourdes Floro, M.D.
- 574** Pediatric Perplexities: Visceral Larva Migrants
Paul J. Hletko, M.D., Chandu Patel, M.D. and Ruth Andrea Seeler, M.D.
- 576** Measles in Suburban Cook County
Colette M. Rasmussen, M.D., M.P.H. and James Mulrooney, B.A.
-

Medical Progress

- 570** Prevention of Accidental Falls in Infancy by Counseling Mothers
Harvey Kravitz, M.D.
-

Medical Legal Review

- 587** Diagnostic Patterns in Disability in Illinois and the Nation
Harry E. Grant, M.D.
-

Surgical Grand Rounds

- 567** Radiation Enteritis
John Beal, M.D.
-

(Contents continued overleaf)

CONTENTS (continued)

Features

- 543 President's Page
573 Clinics for Crippled Children
579 Viewbox
580 New Pharmaceutical Specialties
581 Doctor's News
594 ISMS Guide to Continuing Medical Education
596 EKG of the Month
597 Editorials
599 Membership Forum
602 Pulse of the Doctor's Wife
614 Physician Recruitment
615 Obituaries

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ROCHE announces new

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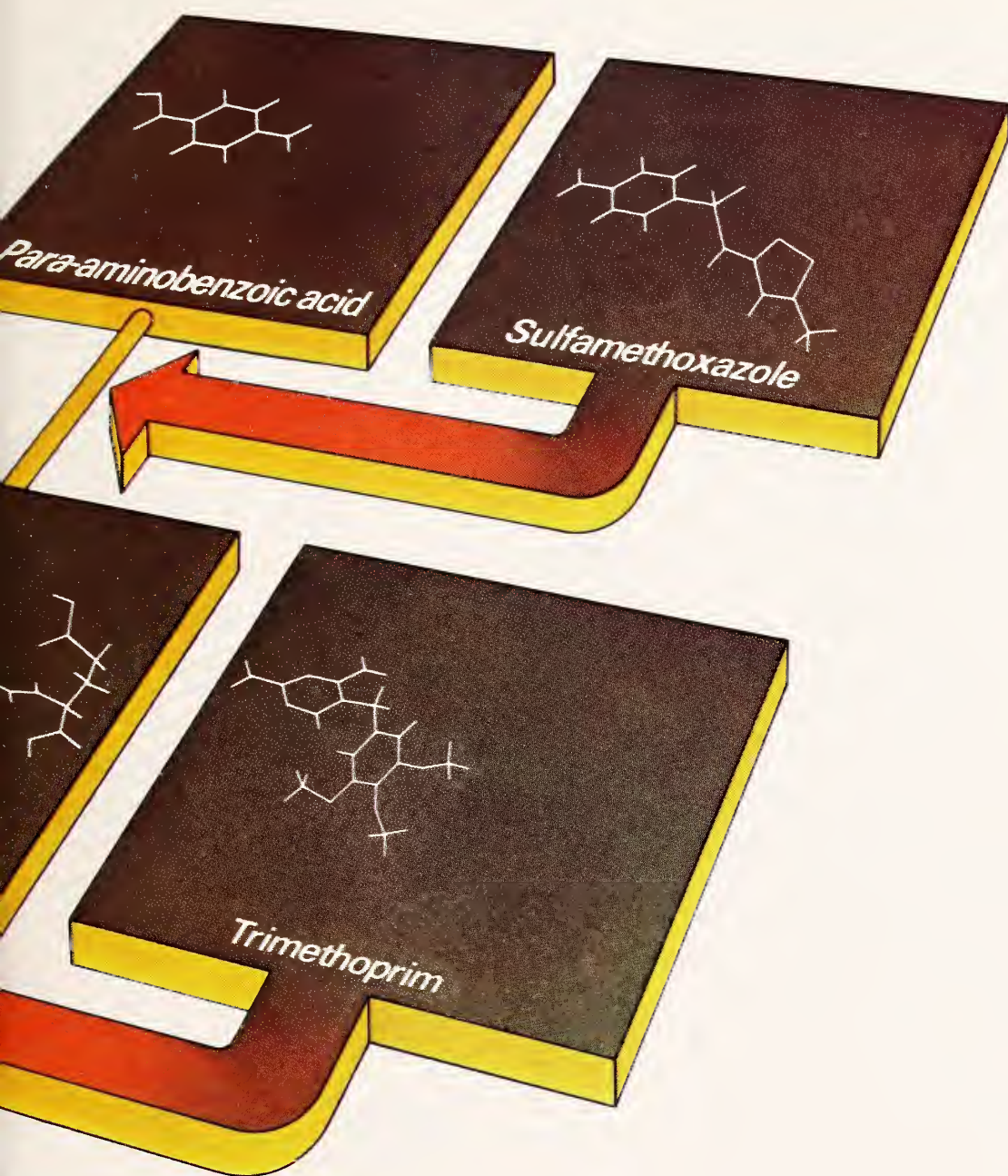
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





new **BACTRIM**^{T.M.}

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.
for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

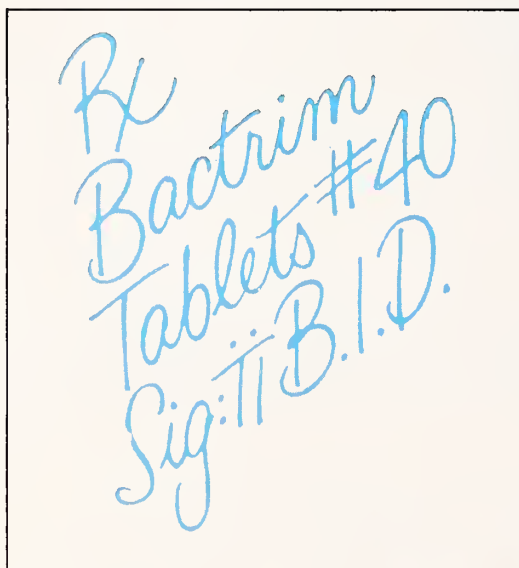
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

[†]4 patients not available for evaluation at day 10.



new **BACTRIM**TM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl)pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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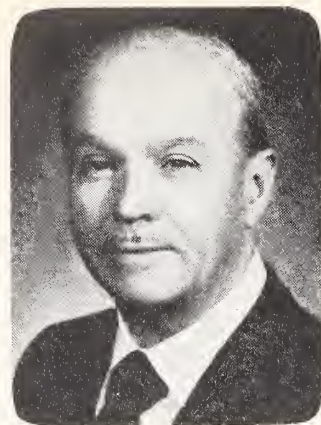


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Medicine Accepts Another Challenge



The federal government handed the medical profession a challenge last fall when PSRO became law. We were assigned the responsibility of assuring the effective, efficient and economic delivery of high quality care under Medicare and Medicaid. Illinois physicians accepted the challenge and have become leaders in implementing PSRO by moving rapidly and effectively to build a statewide review mechanism upon the foundation provided by the successes of the Hospital Admissions and Surveillance Program.

Now a second opportunity to demonstrate medicine's leadership has been given to us by government—an opportunity to assist in implementing a comprehensive program for Medicaid-eligible children which is aimed at identifying, diagnosing, and treating health problems.

In 1967, amendments to Title XIX of the Social Security Act added a requirement to Medicaid that was intended to direct attention to the importance of preventive health services for children.

This amendment requires all states participating in Title XIX to deliver continuing, unfragmented Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to all Medicaid-eligible children up to age 21.

The word *Medichek* has been adopted as the name for Illinois' approach to meet federal requirements for EPSDT. *Medichek* is the Early and Periodic Screening (EPS) portion of the federal requirement. Diagnosis and Treatment (DT) are covered under the state's Medicaid program.

Medichek provides a system for recording basic data from periodic screening and is specifically directed toward preventive care. A specific set of services—including complete periodic physical and dental examinations, immunizations and booster shots, and tests for lead poisoning and sickle cell anemia—already has been established.

Any conditions discovered by examination or screening tests which require further diagnosis and treatment must be followed up by the physician or agency providing the screening or by prompt referral.

Three years have passed since adoption of the EPSDT requirement, yet little—if anything—has been accomplished. Manpower and financial problems have kept the states, including Illinois,

from fully implementing EPSDT.

The EPSDT program is likely to place tremendous burdens upon the health care system. Neighborhood centers and college clinics, hospital outpatient departments and other facilities cannot do the job alone. This program requires the cooperation and participation of physicians and all other health care providers.

The federal government finally has acknowledged the need for our cooperation and participation.

Last May, HEW contracted with the AMA to find solutions to the problems that have kept the EPSDT program from reaching an estimated 13 million American children covered by Title XIX.

During a National Symposium on EPSDT conducted last month by the AMA Committee on Health Care of the Poor, representatives of 28 national medical organizations and health provider groups agreed that EPSDT should be endorsed and supported as an important program delivering comprehensive health care services.

The Committee on Health Care of the Poor selected Illinois as the state to demonstrate how individual physicians, utilizing the expertise of medical organizations, can effectively implement and evaluate a government program.

ISMS already has appointed a task force to plan a statewide conference on EPSDT next month, and to select an Illinois community where ISMS—working with the Illinois Departments of Public Health and Public Aid, local agencies, the county medical society and others—can implement a comprehensive program and test the recommendations made at the national and state conferences. Project results will be used by the AMA to develop a guide for professional provider involvement in EPSDT which will be used by HEW throughout the nation.

Illinois medicine has accepted another challenge. And if Illinois physicians can successfully implement the EPSDT program—a task the federal government itself has not been able to accomplish—we will have demonstrated the absolute necessity for early involvement of physicians in the decision-making stages as well as the implementation of innovative health plans.

William C. Schroeder M.D.

Unity + Strength = Effectiveness

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the
American Academy of Family
Physicians

The Executive Board of the
American Academy of Neurology

The Committee on Drugs of the
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

The Board of Trustees of the
American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Association

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter-professional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005*



The Willing Worker



Intense spasm of the descending colon seen in a 55-year-old female with symptomatology consistent with the irritable bowel syndrome.

with an unwilling colon

A diagnosis of irritable bowel syndrome has not changed her temperament one iota. She still suffers exacerbations of the condition whenever she experiences excessive anxiety that is added to increased responsibility. Yet she continues to accept more responsibilities that require more time and energy and build up more anxiety and tension.

The need to reduce G.I. hypermotility and undue anxiety

The need to reduce G.I. hypermotility is apparent in treating the irritable bowel syndrome. But overanxiety is often perceived as one of the related factors which can contribute to an abnormal increase in motor activity in the colon. When both factors are present, Librax may be a valuable adjunct in therapy.

The dual nature of Librax

As an adjunct to a therapeutic regimen, Librax may help relieve the undue anxiety and associated somatic factors that can contribute to the exacerbation of irritable bowel syndrome. Only Librax combines in one capsule the dependable antispasmodic action of Quarzan® (clidinium Br) and the well-known antianxiety action of Librium® (chlordiazepoxide HCl).

Up to 8 capsules daily in divided doses

According to individual requirements, 1 or 2 capsules, 3 or 4 times daily.

Rx: Librax #35 for initial evaluation of patient response to therapy.

Rx: Librax #100 for follow-up therapy—this prescription for 2 to 3 weeks' medication can help maintain patient gains while permitting less frequent visits.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

For the anxiety-linked symptoms of irritable bowel syndrome

adjunctive
Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



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A NEW INJECTABLE ANTIBIOTIC



Please see last page for prescribing information.

Lilly
introduces
a new
cephalosporin

KefzolTM

cefazolin sodium

Ampoules, equivalent to 250 mg., 500 mg., and 1 Gm. of cefazolin



Its major areas of indication:

respiratory tract infections

due to susceptible strains of *Diplococcus pneumoniae*, *Klebsiella* species, *Hemophilus influenzae*, *Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci (Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.)

genito-urinary tract infections

due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, *Klebsiella* species, and some strains of *Enterobacter* and enterococci

skin and soft-tissue infections

due to susceptible strains of *Staph. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci

See prescribing information for additional indications and susceptible organisms.

Kefzol is contraindicated in patients with known allergy to cephalosporins and should be given cautiously to penicillin-sensitive patients.

Some of its major features:

therapeutic serum levels

peak serum levels of 37.9 and 63.8 mcg./ml. respectively were obtained one to two hours following 500-mg. and 1-Gm. I.M. doses of cefazolin

antibacterial urinary concentrations

peak urine concentrations of approximately 2,400 and 4,000 mcg./ml. respectively were obtained following I.M. doses of 500 mg. and 1 Gm.

bile and synovial-fluid levels

levels approximately one-half those of serum concentrations

flexibility of administration

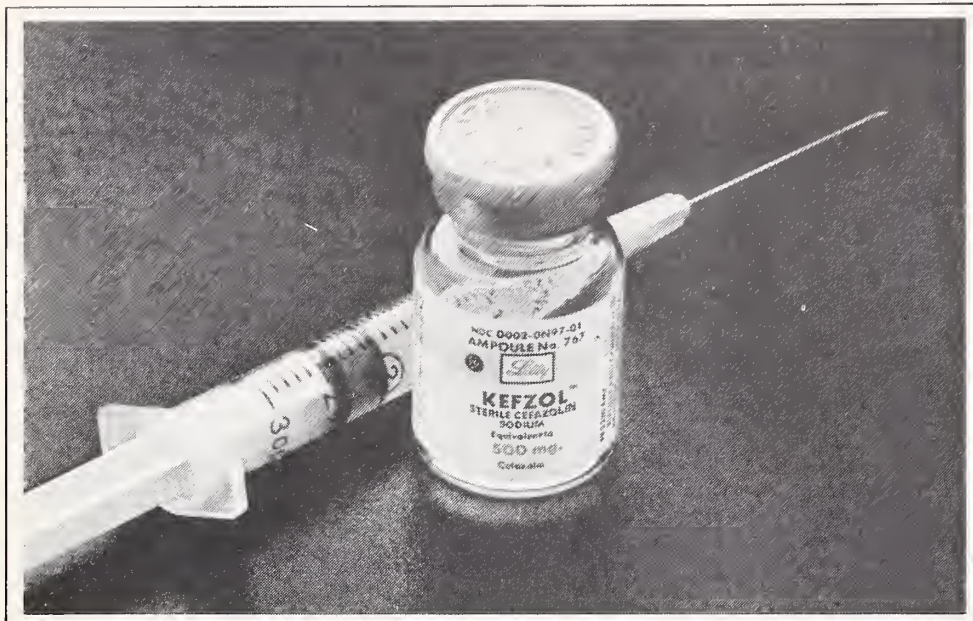
usual adult dosage—500 mg. to 1 Gm. t.i.d. or q.i.d.

Please see following page for prescribing information.

301589

Kefzol™ cefazolin sodium

a new injectable antibiotic



Description: Kefzol™ (cefazolin sodium, Lilly) is a semisynthetic cephalosporin for parenteral administration. It is the sodium salt of 3-[[(5-methyl-1,3,4-thiadiazol-2-yl)thio]methyl]-8-oxo-7-[2-(1H-tetrazol-1-yl)acetamido]-5-thia-1-azabicyclo[4.2.0]oct-2-ene-2-carboxylic acid. The sodium content is 46 mg. per gram of cefazolin.

Actions: *Microbiology*—In-vitro tests demonstrate that the bactericidal action of cephalosporins results from inhibition of cell-wall synthesis. Kefzol is active against the following organisms in vitro:

Staphylococcus aureus (penicillin-sensitive and penicillin-resistant)

Group A beta-hemolytic streptococci and other strains of streptococci (many strains of enterococci are resistant)

Diplococcus pneumoniae

Escherichia coli

Proteus mirabilis

Klebsiella species

Enterobacter aerogenes

Hemophilus influenzae

Most strains of *Enterobacter cloacae* and indole-positive *Proteus* (*Pr. vulgaris*, *Pr. morganii*, *Pr. rettgeri*) are resistant. Methicillin-resistant staphylococci, *Serratia*, *Pseudomonas*, *Mima*, and *Herellea* species are almost uniformly resistant to cefazolin.

Indications: Kefzol is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to *D. pneumoniae*, *Klebsiella* species, *H. influenzae*, *Staph. aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

Kefzol is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of Kefzol in the subsequent prevention of rheumatic fever are not available at present.

Genito-urinary tract infections due to *Esch. coli*, *Pr. mirabilis*, *Klebsiella* species,

and some strains of *Enterobacter* and enterococci

Skin and soft-tissue infections due to *Staph. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci

Bone and joint infections due to *Staph. aureus*

Septicemia due to *D. pneumoniae*, *Staph. aureus* (penicillin-sensitive and penicillin-resistant), *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* species

Endocarditis due to *Staph. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Kefzol™ (cefazolin sodium, Lilly).

Contraindication: KEFZOL IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORINS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics, including Kefzol, cautiously and then only when absolutely necessary. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, intravenous steroids, and airway management, including intubation, should also be administered as indicated.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in premature and infants under one month of age has not been established.

Precautions: Prolonged use of Kefzol may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When Kefzol is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false-positive reaction for glucose in the urine of patients on Kefzol has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported:

Hypersensitivity—Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred.

Blood—Neutropenia, leukopenia, thrombocytopenia, and positive direct and indirect Coombs tests have occurred.

Hepatic and Renal—Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment.

Gastro-Intestinal—Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported.

Other—Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted.

Administration and Dosage: Kefzol may be administered intramuscularly or intravenously after reconstitution.

Dosage—In adults, usual dosage for mild gram-positive infections is 250 to 500 mg. of Kefzol every eight hours. In acute uncomplicated urinary tract infections, a dosage of 500 mg. every eight hours is usually adequate. In moderate or severe infections, the usual adult dosage is 500 mg. to 1 Gm. of Kefzol every six to eight hours. Kefzol has been administered in dosages of 6 Gm. per day in serious infections such as endocarditis. Kefzol may be used in patients with reduced renal function with the following dosage adjustments: In patients with mild to moderate impairment (creatinine clearance of 60-40 ml./min.), 60 percent of the normal daily dose given in divided doses q. 12 h. should be sufficient. In patients with moderate impairment (creatinine clearance of 40-20 ml./min.), 25 percent of the normal daily dose given in divided doses q. 12 h. should be sufficient. In patients with marked impairment (creatinine clearance of 20-5 ml./min.), 10 percent of the normal daily dose given q. 24 h. should be adequate. All dosage recommendations apply after an initial loading dose of 500 mg.

In children, a total daily dosage of 25 to 50 mg. per Kg. (approximately 10 to 20 mg. per pound) of body weight, divided into three or four equal doses, is effective for most mild to moderately severe infections. Total daily dosage may be increased to 100 mg. per Kg. (45 mg. per pound) of body weight for severe infections. Since safety for use in premature infants and in infants under one month has not been established, the use of Kefzol in these patients is not recommended.

How Supplied: Ampoules Kefzol™ (cefazolin sodium, Lilly), Sterile, equivalent to 250 or 500 mg. cefazolin, 5-ml. size, rubber-stoppered; equivalent to 1 Gm. cefazolin, 10-ml. size, rubber-stoppered.



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Panalgesic[®]

RELIEVES PAIN

Usage: Apply where it hurts with gentle massage. May be repeated as often as necessary. A first aid in injuries, relieving pain and discouraging infection. Useful in industrial clinics—collegiate and professional athletic training programs.

**You may request a clinical supply.*

Dispensed in 4 oz. bottles, 6 oz. aerosol spray, pint and half gallon bottles.



Abstracts of Board of Trustees Meeting

October 13-14, 1973

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Physician Bill of Rights

A 12-point Physician Bill of Rights was adopted by the ISMS Board of Trustees and forwarded to the AMA for endorsement by its House of Delegates December 1 in Anaheim, Cal. Drawn up by ISMS President Willard C. Scrivner, M.D., the document is a declaration that physicians will resist increasing interference from government agencies, insurance companies and others outside the ranks of organized medicine.

Physical Exams by Chiropractors

ISMS trustees and officers will urge their congressmen to defeat a proposed amendment to the Motor Carrier Safety Regulations which would allow chiropractors to perform physical examinations on candidates for commercial vehicle driver's licenses. In a related action, the Board re-established a Committee on Quackery.

Proposed Legislative Seminar

The Governmental Affairs Council will explore the feasibility of conducting a legislative seminar for Illinois physicians in 1974. The seminar, which would be financed by a pharmaceutical company, is designed to provide physicians with a better understanding of the governmental process through informal discussions with legislators.

Workshop for New Physicians

ISMS will sponsor an AMA workshop for new physicians entitled "Establishing Yourself in Medical Practice." Funds for the two-day workshop, scheduled for March, 1974, will come from the \$1.00 membership assessment to provide liaison with medical students and physicians-in-training.

Suit Against Federal Government

The Board of Trustees declined an invitation to enter a case which the National Conference of Physicians Unions has instituted against the federal government in connection with the Cost of Living Council limitation on physician fee increases under Phase IV. The Board indicated that since the issue is national in scope, the request should be directed to the AMA.

Board of Trustees Meetings

The following schedule of meetings of the Board of Trustees was approved:

Feb. 3-6, 1974—Statler Hilton, Washington, D.C.

Apr. 3-6, 1974—Conrad Hilton, Chicago (annual meeting)

June 1-2, 1974—Marriott Motor Inn, Chicago (Journalism Awards)

Aug. 2-3, 1974—Sheraton Oakbrook, Oak Brook

Oct. 12-13, 1974—Ramada Inn, Carbondale

Jan. 18-19, 1975—Hyatt Regency, Chicago

The February Board meeting will be held in conjunction with the annual Wash-

ington Roundup, which will be followed by an educational seminar-vacation trip to St. Maarten Island in the Dutch Antilles. The Washington Roundup and Caribbean excursion are open to all members.

Continuing Medical Education

The following were re-elected to the Board of Directors of the Illinois Council on Continuing Medical Education:

Drs. Dean Bordeaux, J. Ernest Breed, Edward W. Cannady, Willard DeYoung, Robert T. Fox, Mather Pfeiffenberger, George Shropshear and Boyd McCracken. The ISMS Board will request the House of Delegates to continue its \$10-per-member allocation of AMA-ERF Contribution.

ISMS officers and trustees received the first copies of YOUR PERSONAL LEARNING PLAN, the new ICCME guide to continuing education.

In a related action, the Board endorsed the idea that special recognition be afforded those agencies and institutions achieving accredited status for continuing medical education and The Speaker of the ISMS House of Delegates will be asked to provide a suitable time for this recognition.

Hotel Rates for ISMS Members

All officers, trustees, council and committee members will be requested to reserve Chicago hotel rooms through ISMS headquarters so that special rates may be obtained at the LaSalle, Sheraton-Chicago, Oxford, Drake and Pick-Congress hotels. This service is open to all ISMS members staying in Chicago on society business.

Council on Affiliate Societies

The newly-formed Council on Affiliate Societies has been authorized to allow substitutes from the respective specialty societies to attend council meetings in the absence of the principal representatives. Although this provision is unique in the ISMS council structure, it will be allowed because of the nature of this council.

HIC Response to Peer Review Guidelines

The Council on Economics and Peer Review will meet with Health Insurance Council representatives to iron out differences in peer review guidelines. HIC has objected to the original guidelines developed by the ISMS council and approved by the Board previously.

IDPA Payments

The ISMS Committee on Governmental Health Care Reimbursement will meet with Chicago Medical Society representatives to discuss delays in Illinois Department of Public Aid payments to physicians and the Board of Trustees will formally express to IDPA its displeasure over slow processing of claims. Subject to legal counsel's approval, the Board will inform IDPA that its continuing delay in processing physician's claims will affect adversely physician participation in the IDPA program and the quality of patient care under that program.

In a related action, the Board will request IDMH to review regulations limiting psychiatric treatment of public aid recipients to \$300 maximum per year and a 10/20 day limit on in-patient care.

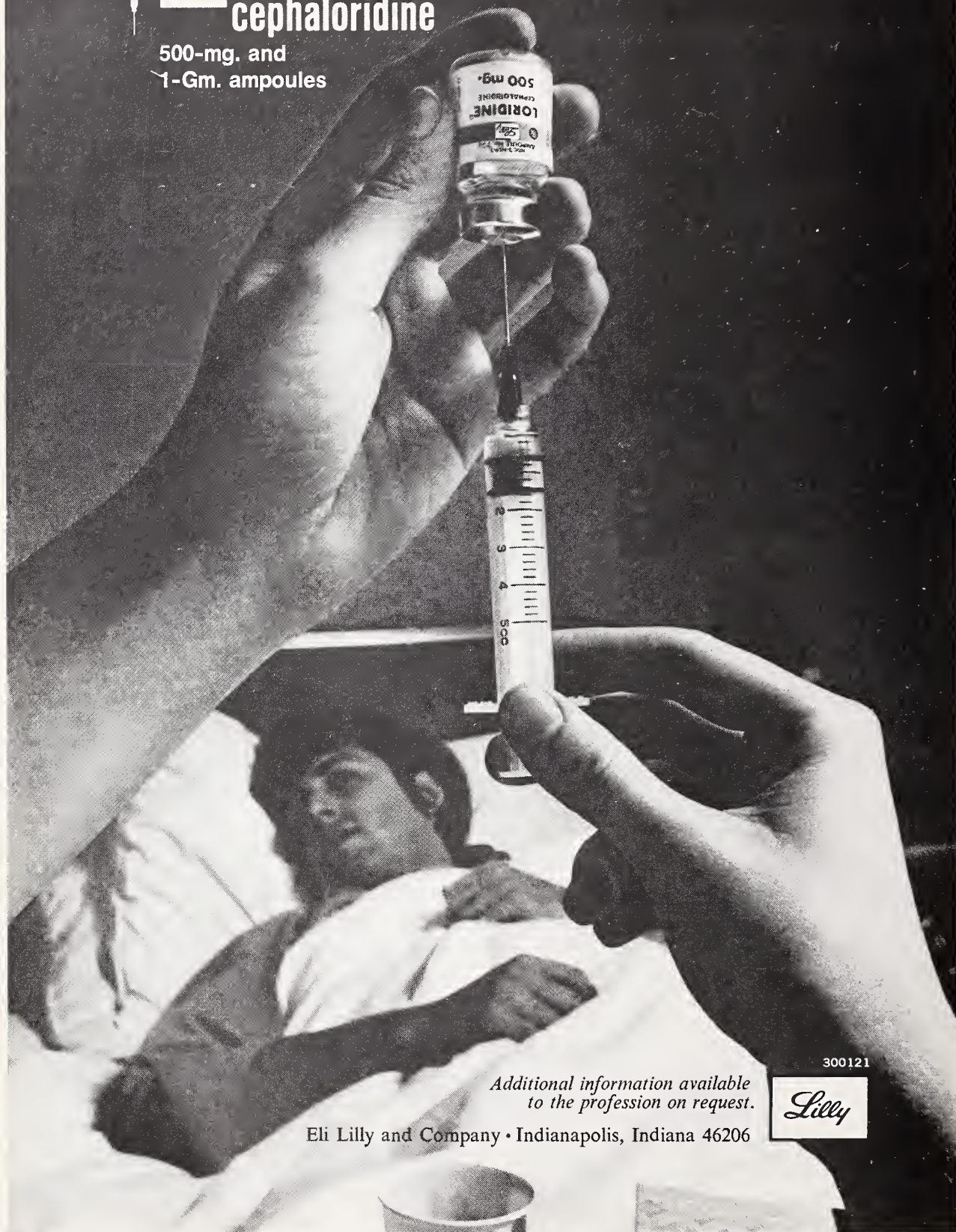
Aging

The following ISMS members will be nominated for a council being developed to advise the new State Department of Aging:

(Continued on page 606)

loridine[®] I.M. cephaloridine

500-mg. and
1-Gm. ampoules



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Illinois Medical Journal

Vol. 144, No. 6, December, 1973

Foreign Trained Physicians in Illinois

BY KONG MENG TAN, M.D./CHICAGO

Since 1963, one out of every two physicians added to the total U.S. physician pool has been foreign trained.¹ By 1970, these 57,217 foreign medical graduates (FMG's) represented 17.1% of all physicians in the U.S.¹ It is estimated that this increasing influx of FMG's account for the rise in the ratio of total doctors to population from 145 per 100,000 in 1950 to 164 per 100,000 in 1972.²

Illinois depends to a very large extent on FMG's and indications are that this dependence will rise.

Table I is a survey of the number of internships in Illinois from 1967-72. As of September 1, 1972, there were 511 graduates of foreign medical schools, and 280 U.S. and Canadian graduates serving as interns. The percentage of FMG's in Illinois internships has progressively risen from 47% in 1967-68 to 65% in 1972-73. Although the number of internship positions increased, the number of U.S. and Canadian graduates annual-

ly actually decreased over a 6 year period. Only seven states had 50% or more FMG's in internship positions—Delaware, North Dakota, Illinois, Michigan, New Jersey, Ohio, and Rhode Island.

Table II indicates that by September 1, 1972, there were 1342 FMG's and 1187 U.S. and Canadian graduates serving as residents in Illinois. Again, the annual percentage of FMG's occupying residencies rose progressively from 45% in 1967-68 to 53% in 1972-73. Since 1967, FMG's filled three out of four additional residency positions in Illinois. Only five other states, Delaware, North Dakota, Nevada, New Jersey, and New York had FMG's in 50% or more of their filled residencies.

A combination of Tables I and II (Table III) indicates that the percentage of FMG's in intern and resident positions rose progressively by the year from 45.9% in 1967-68 to 55.8% in 1972-73. As of September 1, 1972 there were 1853 FMG's in housestaff positions (excluding trainees in fellowships and research positions for which figures are unavailable at this time), accounting for 10.1% of all FMG's in the U.S. at that date.³

It is of interest to note that although housestaff positions are offered at three hospitals each in Peoria and Rockford, and two hospitals in Springfield, there are only 43 housestaff (22 are foreign trained) situated outside of Chicago and its immediate suburbs.⁴

An attempt to tabulate the number of internships and residencies in Illinois by medical school affiliation and bed capacity was unsuccessful.



KONG MENG TAN, M.D., Chicago, is a radiology resident and the immediate Past President of the House Staff at Illinois Masonic Medical Center. A graduate of the University of Illinois College of Medicine, Dr. Tan presently serves on the Advisory Committee to Medical Students and Physicians in Training

of the ISMS Council on Education and Manpower, and is the Housestaff representative to the Illinois Council on Continuing Medical Education. He was recently appointed to the AMA Committee on Housestaff affairs.

TABLE I
NUMBER OF INTERNSHIPS IN ILLINOIS 1967-72

Year	No. of Hosp.	No. of Appr. Programs	No. of Intern Pos. Offered	No. of Intern Pos. Filled	% of Pos. Filled	No. of FMG's	% FMG's	No. of U.S. & Can. Grads.
1967-68	42	157	859	701	82	332	47	369
1968-69	44	165	949	728	77	360	49	368
1969-70				Figures unavailable				
1970-71	50	186	1026	749	73	399	53	350
1971-72	47	185	977	804	82	502	62	302
1972-73	47	172	922	791	86	511	65	280

(Adapted from *Medical Education in the United States 1972-73*, JAMA Nov. 19, 1973, Vol. 226, No. 8)

TABLE II
NUMBER OF RESIDENCIES IN ILLINOIS 1967-72

Year	No. of Hosp.	No. of Appr. Programs	No. of Res. Pos. Offered	No. of Res. Pos. Filled	% of Pos. Filled	No. of FMG's	% FMG's	No. of U.S. & Can. Grads.
1967-68	61	239	2126	1848	87	837	45	1011
1968-69	62	226	2201	1902	86	877	46	1025
1969-70				Figures unavailable				
1970-71	62	242	2587	2213	86	1081	49	1132
1971-72	61	236	2558	2306	90	1180	51	1126
1972-73	74	244	2790	2529	91	1342	53	1187

(Adapted from *Medical Education in the United States 1972-73*, JAMA Nov. 19, 1973, Vol. 226, No. 8)

TABLE III
FOREIGN TRAINED PHYSICIANS IN TRAINING PROGRAMS IN ILLINOIS

Year	Interns	Residents	Total Positions Filled	% of FMG's
1967-68	332	837	2549	45.9
1968-69	360	877	2630	47
1969-70			Figures unavailable	
1970-71	399	1081	2962	49.6
1971-72	502	1180	3110	54
1972-73	511	1342	3320	55.8

Adapted from Tables I and II

However, figures available⁵ indicate they follow the national trend closely. Thus, foreign trained interns gravitated towards non-affiliated hospitals with low bed capacities, although there were significant numbers of foreign trained physicians in teaching hospitals closely linked with medical schools. With the increasing number of FMG's in Illinois residencies and the increasing trend towards affiliation of some sort with a medical school, it is felt that figures representing foreign trained physicians in Illinois hospitals in terms of affiliation and bed capacity will be of dubious statistical value.

Table IV indicates the top ten foreign countries supplying graduates to Illinois graduate medical education programs as of December 31, 1970. The total figures exclude Canadian graduates. The list of countries correlates well with the data in Dublin's article⁶ on the migration of

TABLE IV
FOREIGN COUNTRIES CONTRIBUTING GREATEST NUMBER OF GRADUATES TO ILLINOIS GRADUATE PROGRAMS AS OF DEC. 31, 1970. EXCLUDES CANADIAN GRADUATES

Country	No. of Interns & Residents
1. Philippines	310
2. India	282
3. Thailand	113
4. S. Korea	99
5. Iran	77
6. Taiwan	72
7. Pakistan	64
8. Colombia	38
9. Bolivia	30
10. Peru	30

Adapted from "Foreign Medical Graduates in the United States 1970," Center for Health Services Research and Development, AMA, Chicago.

physicians to the United States. He shows that the proportional contribution of emigrant physicians from Western European countries has declined, while the percentage of emigrant physicians from the Far East has risen seven times from 1965 to 1970, and now comprises well over half the total.

Table V indicates that as of 1970 the foreign countries contributing the largest number of physicians to office based and full time practice in Illinois were either European or South American countries. Only two Far Eastern countries made the top ten. The trend noted by Dublin started fairly recently, and when most of these physicians have finished their residencies, it is anticipated that other Far Eastern countries, i.e.: Thailand, S. Korea, Taiwan and the Philippines, will join the list.

TABLE V
FOREIGN COUNTRIES CONTRIBUTING
GREATEST NUMBER OF GRADUATES TO OFFICE
BASED AND FULL TIME PHYSICIAN PRACTICE
IN ILLINOIS AS OF DEC. '70.
THIS EXCLUDES CANADIANS

Country	No. of Office Based and Full Time Physicians
1. West Germany	372
2. Cuba	255
3. Philippines	215
4. Austria	126
5. U.S.S.R.	116
6. Italy	99
7. Mexico	99
8. Greece	86
9. India	85
10. Switzerland	70

Adapted from "Foreign Medical Graduates in the United States 1970," Center for Health Services Research and Development, AMA, Chicago.

By December, 1970, foreign trained physicians accounted for 27.8% of all Illinois physicians (4542 out of a total of 16,323). Of those 4542, 2348 were fully licensed and 2194 were not.

In 1972 the Illinois Department of Registration and Education issued 1644 licenses to qualified physicians, 758 by examination, and 886 by reciprocity and endorsement; 826 licenses represented additions to the medical profession, i.e., physicians who secured their first licenses to practice in 1972. Of these, 632, or 76.5%, were FMG's.⁷ FMG's examined in Illinois totalled 1288 with a failure rate of 39.4%.

Nationwide, FMG's accounted for 40% of additions to the physician manpower pool in 1972.⁷ There were more than twice as many FMG candidates in 1972 as there were in 1970; the failure

rate varied within 3 percentage points: 37.3% in 1970, 34.9% in 1971, and 36.2% in 1972.⁷ This increase in the number of foreign graduates seeking permanent licensure reflected to some extent the relaxation of citizenship requirements of several state boards of medical examiners as well as changes in the U.S. immigration laws, effective July 1, 1971.

TABLE VI
FOREIGN TRAINED PHYSICIANS RECEIVING
INITIAL LICENSES FROM ILLINOIS STATE
BOARD OF MEDICAL EXAMINERS

Year	Examinations	Reciprocity and Endorsement
1966	77	0
1967	114	0
1968	96	0
1969	85	1
1970	107	0
1971	162	7
Total	641	8

Adapted from Medical Licensure Statistics for 1971, AMA Sept. 1972.

Discussion

Pierre de Vise, in a recent provocative and interesting article,⁸ noted that more Illinois trained doctors end up in California than stay in Illinois. They do so not only because of the attractive climate, the glamor and the higher housestaff stipends, but for the future it promises practicing physicians. California receives three times more federal aid per graduate than Illinois, two and one half times as much Medicaid money, and one third more Medicare money.

In 1970, Illinois filled 34% of its 1026 internships and 44% of its 2587 residencies with American graduates. In contrast, American graduates filled 85% of California's 1443 internships and 84% of its 4407 residencies.³

In 1971, California retained 70% of those educated in the state for their period of graduate education as against Illinois' 34%.³

California has no plans to increase the number of its medical schools or their enrollments, whereas Illinois has felt it more than necessary to do both.

Thus, de Vise raises the somewhat amusing spectre of Illinois training more physicians simply to send more to California and other attractive areas.

Therefore, it is conceivable that for many more years to come foreign trained physicians will continue to fill a very large percentage of the housestaff positions available in Illinois and conse-

quently contribute more physicians to the communities of Illinois.

Dublin⁶ considers the United States to be a "debtor" nation in terms of its current supply of physicians. With rising consumer interest in increased health services and consequently more training programs established, it is highly conceivable the U.S. will continue to import foreign trained physicians for many years to come. He believes, and this author agrees, that this will occur despite increased efforts to shorten the curriculum, enlarge student enrollments and build new schools.

This continued importation will be of financial benefit to Illinois. Dr. H. Van Zile Hyde, Director of the Division of International Medical Education of the Association of American Medical Colleges, estimates that the 40,000 FMG's in the U.S. represent an annual savings of some \$600 million.⁹ Thus, the 1853 foreign trained interns and residents in Illinois in 1972-73 represented a savings of approximately \$28 million to the people of Illinois.

The strong pull factors operating in the U.S. will only tend to reduce the number of physicians in countries where they are badly needed. It will lead to deterioration of U.S. relations with those countries and aggravate the impression that the United States is "far more interested in the integration and utilization of FMG's into its own health system than in orienting their training programs towards the needs of their home country."¹⁰ Have we indeed lost sight of the original purposes for which foreign trained physicians first started coming to this country?

There is evidence to suggest that many U.S. hospitals employ FMG's for pure service needs. Graduate education programs of high quality or suitable training programs geared towards the practice of medicine in foreign countries, especially the developing nations, are lacking in such hospitals. Even when hospitals have decent graduate education programs, service needs command first priority. As de Vise succinctly points out, this is totally "(not) consistent with the intent of international educational exchange legislation governing the admission of exchange visitor physicians to the U.S."⁸

Many published studies have purported to show that the performance of most FMG's rate as less than adequate. However, one must view most of these studies with something of a jaundiced eye. Most FMG's suffer by comparison with U.S. graduates because their diverse differences in background, language difficulties, cultural dif-

ferences, etc. are not given sufficient weight. Modifications in U.S. training programs to accommodate such differences receive low priority. Identical criteria to evaluate the performance of FMG's and U.S. graduates puts the FMG at a disadvantage.

Halberstam et al¹¹ show that only 14% of foreign educated interns indicated they were satisfied with their experiences and that 27% saw themselves as unsupervised. In hospitals without Directors of Medical Education (DME) or persons in comparable positions, 41% of interns indicated their supervision was inadequate, while in hospitals with DME's, this figure fell to 18%. An unsatisfied group as large as this obviously cannot be ignored by those responsible for organization and maintenance of high quality training programs. Although this study was done in the northeastern United States, there is no reason to indicate the statistics will not stand up in Illinois.

Thus, those hospitals without Directors of Medical Education, but who do have a housestaff, should consider acquiring a DME. It is extremely important to discontinue the recruitment of FMG's for purposes of service under the guise of learning, and to create, instead, the necessary diverse educational programs that are better matched to individual backgrounds and our national needs. We have to return the housestaff training program toward an emphasis on education and away from its emphasis on service.

It may be appropriate, therefore, to consider the establishment of programs in hospitals to differentiate between immigrants who would become part of the future manpower pool in the U.S. and those exchange visitors who would eventually return to their own countries. In either case, the quality of graduate education programs in Illinois hospitals will have to be strictly regulated, a role which easily falls within the purview of the ISMS Council on Education and Manpower, the Liaison Committee on Graduate Medical Education, and the Illinois Council on Continuing Medical Education. FMG exploitation has to be condemned and rooted out wherever it exists.

Licensure problems bother FMG's a great deal. In Illinois it has become relatively easier for FMG's to obtain licenses than in other states. However, multiple examinations and discriminatory regulations in certain other states with regard to licensure remain.

The U.S. medical graduate in Illinois takes Part I of the examination of the National Board

of Medical Examiners (NBME) at the end of his sophomore year, Part II at the end of his senior year, and after passing Part III at the end of his internship is eligible for permanent licensure.

The FMG, on the other hand, has to pass the examination of the Educational Council of Foreign Medical Graduates (commonly called the ECFMG) which is an examination drawn from the pool of NBME questions in order to enter a graduate training program. At the end of a year of graduate training he is eligible to sit for the FLEX, another examination covering the entire gamut of medical knowledge. He is not eligible to participate in the NBME. In effect, he undertakes two examinations to qualify for licensure, while U.S. graduates qualify through one examination taken over a number of years.

It is time, perhaps, to consider substituting the ECFMG examination with Parts I and II of the National Boards, and allowing the FMG to take Part III at the end of one year of training. Certainly, relaxation of licensure requirements for FMGs to conform more closely with those for U.S. graduates should be considered.

The benefits of training and the services provided are proportional to the adjustment of foreign physicians to U.S. life.¹² With increasing numbers of FMGs coming to Illinois, it is logical to assume that programs directed towards housestaff will need to gear themselves towards the particular needs of FMGs.

Efficiency and effectiveness of FMGs are markedly affected by the above mentioned language, cultural and other problems. They are unable to reap as much benefit from their post graduate program as they should. Without communication, their education suffers, and their contributions to hospital activities are diminished. The quality of patient care can and does suffer. The enjoyment and value of both medical and non-medical aspects of U.S. life are lost.

The Philadelphia Medical Society runs a program for FMGs that includes orientation, English language instruction, social and cultural opportunities, sight-seeing tours, home hospital-ity service to families, and promotion of integration into the community.¹³ There is no reason to assume that the Chicago Medical Society and the Illinois State Medical Society are capable of less. For the past four years a group of ladies from the Woman's Auxiliary to the Chicago Medical Society have held "Orientation U.S.A." at a Chicago hospital. They host the foreign medical graduates in their homes as well as teach them American phrases and orientate them to their new environment. More can and should be

done.

Illinois physicians must never make the mistake of judging or misjudging all FMGs by the one example they know. Varied backgrounds, medical and nonmedical, produce different types of physicians. Differences in education exist from country to country. One must condemn the somewhat prevalent assumption that the mere fact of having studied abroad automatically makes one inferior in skills.

There must be increased daily contacts between the FMG and his supervisors. This cannot be done in an atmosphere of condescension. The FMG is as intelligent and cultured as the next man, and can easily distinguish between the attending physician who is genuinely interested in him and the one who merely is polite. Cautious development of pride in the department and the hospital has to be fostered. There has to develop a camaraderie, an esprit de corps. Thus, social contacts between both sides should be encouraged, both within and without the hospital. Perhaps, within this context, the visitation program now being evolved that brings together medical students with downstate physician communities could be expanded to include FMGs.

Summary

Increasing numbers of foreign trained physicians come to Illinois as housestaff. Slightly more than one in two housestaff in Chicago, which accounts for more than 98.5% of housestaff in Illinois, are FMG's. Increasing numbers of FMG's also are receiving permanent licensure in Illinois. Problems facing FMG's are many and varied. Plans to overcome them must be constantly reviewed and organized medicine must play active and positive roles towards this end.

Acknowledgement

The author wishes to thank Mrs. Geri Davis, Office of Medical Education at Illinois Masonic Medical Center, for her gracious help in the typing of this paper and for her constant encouragement. ◀

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(Continued on page 604)

Headache Associated With Low Spinal Fluid Pressure Syndrome

(Primary Intracranial Hypotension)

BY SEYMOUR DIAMOND, M.D. AND BERNARD J. BALTES, M.D., Ph.D. /CHICAGO

Positional headache is seen rarely even among those specializing in neurological and headache problems. The purpose of this paper is to alert the practitioner of the possibility of low spinal pressure syndrome and to alert them that it can occur especially with positional headache.

Usually, headache aggravated by being in the upright position is accompanied by a spinal fluid pressure of less than 70 mm. cerebrospinal fluid in the lateral recumbent position.¹ The etiology may be:^{2,3} (1) primary (spontaneous); (2) following cranial operation (particularly evacuation of a subdural hematoma); (3) post-traumatic (either with or without manifest external loss of CSF); (4) after lumbar puncture or nerve sleeve tears (continued leakage);^{1,3} (5) general medical conditions associated with dehydration, decreased cerebral blood flow. Schaltenbrand^{5,6} originally described the syndrome of spontaneous intracranial hypotension. He mentioned the resemblance of the symptomatology to that of post-lumbar puncture headache. Headache is present in the upright position and is relieved by recumbency. Nausea, vomiting, vertigo, pallor, and sweating may accompany the headache. The cerebrospinal fluid pressure is always very low (below 70 mm. of cerebrospinal fluid). There may even be a negative pressure so that air is sucked into the needle when the stylette is removed. The fluid may contain a few white and red blood cells and a moderately elevated protein. Symptoms last from 2 to 16 weeks and subside spontaneously.

There is no specific treatment and, to date, the cause is unknown.

Subsequent to Schaltenbrand's description, additional cases have been reported.^{1,4,7} Suchenwirth⁸ reviewed all of the cases published prior to 1962.

The two cases we will describe present the following prevalent characteristics. The most unique is an orthostatic headache. It is usually gradual but may be sudden in onset and is characteristically aggravated in the upright position. Vertigo is present along with nausea, vomiting and some neck rigidity. Schaltenbrand described a "vagus pulse" or bradycardia and further noted a mental dullness, confusion and that sometimes convulsions or psychiatric disturbances may occur. An important feature is that the prognosis depends largely upon the etiology.

Case Reports

The authors have observed two such cases of low spinal pressure syndrome. The first is one of spontaneous type and the other after an episode of head trauma in which there was a fracture of the sphenoid bone in front of the sella turcica.



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Case 1: This 42-year-old female was admitted to St. Joseph Hospital because of a two week's history of severe, dull, bifrontal headache. There was no history of head trauma.

The patient's headaches were aggravated when standing and markedly relieved by recumbency. Vertigo, nausea and vomiting were the only associated symptoms.

Her general and neurological examination was entirely normal except for a sinus bradycardia of 48 per minute. Skull X-ray, brain scan and EEG all were normal. Lumbar puncture in lateral recumbent position revealed a minimal flow of fluid and opening pressure was thus recorded as less than 30 mm. of cerebrospinal fluid. Lumbar puncture was done at two levels for verification. Analysis of spinal fluid revealed 8 WBC/cu.mm. and a protein value of 49 mg%. Pneumoencephalogram was negative. Bilateral carotid angiography revealed questionable X-ray findings but raised the possibility of bilateral subdural hematoma. Repeat brain scan was negative.

On the 11th hospital day, 40 cc. of normal saline was injected intrathecally, thus raising the spinal fluid pressure from an opening pressure of 30 mm. of cerebrospinal fluid to a closing pressure of 160 mm. of cerebrospinal fluid. This was accompanied with immediate relief from the headache. Bilateral parietal exploratory craniotomies were performed on the 21st hospital day and revealed bilateral subdural hygroma which was evacuated. Thickening of the membranes was noted. Post-operative course was uneventful.

The headaches disappeared completely. She was discharged on the 28th hospital day without symptoms and has had no recurrence of her headaches.

Case 2: This 21-year-old male was admitted to Illinois Masonic Hospital one day after being involved in an automobile accident in which he was apparently struck on the head. He was unconscious immediately after the accident for an hour and after that he was responsive but dull and disoriented. There were no focal neurologic signs. No external leakage of CSF from nose or ears. Cloudiness of sensorium was the only finding. X-rays of the skull, cervical spine and facial bones all were normal except for a nasal fracture of sphenoid bone in front of sella turcica without displacement (good position). EEG and echoencephalogram also were reported normal. During the days after admission he gradually improved and became more alert and responsive. A lumbar puncture on the seventh hospital day revealed a clear, colorless fluid and a pressure of 140 mm. of cerebrospinal fluid. There were 38 RBC/cu.

mm. and a protein content of 62 mg%. Ten days after admission he was conscious, alert, responsive and cooperative and was discharged to resume his normal activity. He returned to the hospital three days later complaining of a headache aggravated in upright position and markedly relieved by recumbency. He described it as a dull, constant pain "all over the head" associated with nausea and vomiting.

General and neurologic examination was completely negative.

At lumbar puncture the manometer failed to register any pressure and thus one cc. of CSF was aspirated for lab, then 40 cc. of saline solution was injected intrathecally. Pressure rose up to 110 mm. of cerebrospinal fluid and the patient was able to sit up immediately without pain. CSF analysis showed 61 RBC/cu.mm. and protein 97 mg%. He improved in the hospital and was discharged one week later asymptomatic and has remained so ever since.

Comment

The first case is an example of spontaneous intracranial hypotension which was first described by Schaltenbrand and he employed the term "aliquorrhea".⁵ Pathogenesis is generally postulated to be a reduction in production of CSF (either directly due to a localized reflex vasospasm of the choroid plexus or disturbance of hypothalamic centers which control its production). Lasater¹ believes that in this syndrome there always is a leakage of CSF from a tear in the membranes, the cause of which could have been a minor trauma (simple fall, strain, etc.) which might easily have gone unnoticed to the patient. One argument to support this theory is the cases of spontaneous intracranial hypotension developing after a fall on buttocks which have produced a rupture in the dural sleeve of a lumbar nerve root.

Of notable interest in Case 1 is the finding of BILATERAL subdural hematomas which is infrequently reported⁸ to develop as a complication of this disorder and is attributed to abnormal engorgement of the cerebrovascular system as a compensatory mechanism to reduce intracranial pressure.³ Case 2 clearly typifies, except for the red blood cells in the spinal fluid, the classical description of post-traumatic low spinal fluid pressure in which lumbar puncture soon after a cranial trauma reveals a normal or slightly increased pressure. However, after a period of (4 days to 3 weeks) time, along with occurrence of

(Continued on page 601)

The Treatment of Accessible Malignant Tumors by Irradiation

BY J. ERNEST BREED, M.D./CHICAGO

The most successful treatment of any malignant tumor is its complete destruction before it has metastasized. A cancer usually reaches a palpable size and has been present for an appreciable length of time before it spreads, although I have seen a mammary tumor 2 mm. in diameter which had already involved the axillary lymph nodes.

Tumors seldom cause subjective symptoms or functional disturbances until attaining considerable size. It follows, therefore, that deep-seated tumors frequently have metastasized before discovery. This accounts for the low salvage rate for cancers of the lungs, stomach and most other deep-seated organs.

The accessible tumors—those of the skin, mouth, pharynx, larynx, breast, and uterus—can usually be diagnosed relatively early, and in general should have a good prognosis. Because of the mobility of the breast, a highly anaplastic cancer may spread before the primary growth is suspected, and occasionally the first sign of a head or neck cancer is the appearance of lymph nodes in the cervical area. Fortunately these occurrences are unusual. At times, vaginal bleeding resulting from neoplasia will be mistaken for an abnormal menstrual period, and neglected. In this area, the Pap smear has done a great deal to assist in the early detection of a malignant growth.

Early diagnosis of cancer of the skin should be possible because the patient is usually aware of the presence of an abnormality from its inception. At times, however, the patient is not wor-

ried by a small, painless lump or ulceration and may delay seeing a physician until cure by any means is difficult or impossible.

One might believe that a patient would always be aware of a growth in the mouth, but I have seen some relatively large mouth cancers of which the patients were unaware until the bulk of the growth interfered with mastication.

Treatment

The purpose of treating a cancer patient is the same as treating a patient with any other disease, and that is to return him to his previous "normal" state both physically and mentally. This is seldom possible in the treatment of cancer because surgical procedures always leave scars, and radiation therapy produces some atrophy in the adjacent tissues. At times, with either form of treatment, cancer cells may be locked in scar tissue and remain viable for long periods of time. The major hope, then, is that the patient be so treated that his cancer is destroyed, or that any cancer cells remaining will be immobilized so as not to interfere in any way with his completing a normal span of life.

There are several methods of destroying accessible tumors. The most reliable are conceded to be surgery and irradiation, or a combination of the two. The skill, knowledge, and experience of the surgeon or radiotherapist are modifying factors. Patients with cancers that could be treated equally well by either method would fare better with an experienced cancer surgeon than with an inexperienced radiotherapist, and the opposite also is true.



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Treatment By Radiation Therapy

The treatment of accessible tumors by radiation offers a unique opportunity to deliver a very high dose of radiation to the tumor without materially injuring the adjacent structures, if a radiation source such as radium or cobalt can be placed within the growth or near the surface. This is because of the inverse square law, which states that the intensity of radiation varies inversely as the square of the distance from the source. The radiation technique, popular for many years, primarily utilized intratumoral treatment in the form of radium needles or radon implants, or treatments to the surface of the growth with radium molds. Because of a great increase in the use of ionizing radiations in research, diagnosis, and therapy, injuries sustained by some workers in a radiation facility, or persons caught in the area of an exploding atomic bomb, the public and the medical profession were so disturbed that all precautions are used to minimize the amount of radiation received by those working with ionizing radiations.

New Sources of Radiation

In the past 20 years, large amounts of money have been spent to produce high energy radiation which can be administered at great distance from the skin's surface. This permits massive doses to be delivered deep within the body without prohibitive injury to the skin. Cobalt 60, with its five-year half life, produces isochromatic gamma rays of about the average energy of the natural rays of radium. Radioactive cesium, with its longer half life (30 years), produces a gamma ray with roughly two-thirds the energy of either radium or cobalt. Various mechanical devices energizing particles such as protons, neutrons, or electrons have been used directly in the tissues or to produce high energy X-rays. High energy radiation can be delivered in a shielded room and controlled from outside, a method that has become popular, particularly in the treatment of deep-seated, unresectable tumors, some of which may be quite radiosensitive.

This method in accessible tumors, however, requires careful evaluation because the inverse square law dictates that tissues around the tumor and even beneath it receive essentially the same dose as the tumor when the source is 30 or 50 centimeters from the skin surface. It is, therefore, impossible to administer a very high dose to the accessible tumor and still spare the adjacent tissue.

Recently, there has been a resurgence of interest in brachytherapy (short distance radiation therapy). Powerful sources may be transferred by remote control from a reservoir to a prefixed applicator. The English have built a unit called the Cathetron, which consists of cobalt 60 sources pushed with a cable from a reservoir through a long tube to prefixed vaginal ovoids or into an interuterine applicator. In their experimental work, they have followed the "Manchester" dosage system for treatment of cancer of the cervix. On examination of various tissues in the area, they have discovered that short treatment of a powerful Cathetron applicator, repeated on the same time schedule as in the Manchester System, produces essentially the same microscopic changes in the tissues. The Atomic Energy of Canada, Ltd. has built a similar unit that they call the Brachytron.

In 1972, at Mount Sinai School of Medicine New York, a conference was held on "Afterloading in Radiotherapy." It was attended by about 500 physicians from all over the world, and many new types of afterloading devices were displayed. Although major concern was with surface applicators, the placement of radioactive sources intratumorally through a prefixed tube also was considered.

For many years, my work has chiefly consisted of the treatment of accessible tumors with radium or cobalt by short distance, high intensity techniques. This involves the placement of powerful applicators over the surface of the tumor for short treatments given daily or on alternate days. Although this technique was quite effective, I realized that others would not embrace it because the radium or cobalt sources needed to be placed by hand, even though the operator was fully protected behind thick lead blocks.

Several years ago, I conceived the idea of transmitting small, but powerful, sources of radioactive cobalt pneumatically from a lead reservoir to a prefixed applicator. First, in order to demonstrate the effectiveness of high intensity, short distance treatment, I reported on 344 patients with mouth cancers,¹ disclosing a 70% destruction of the primary tumor in combined Stages I, II and III. Most of the Stage I patients recovered without trouble and the more advanced Stage III tumors were less curable. My idea was developed by the Breed Corporation and its consultants, who proposed the encasing of cobalt in the center of a titanium ball bearing that would then be inserted into a radioactive pile.² The

(Continued on page 600)

Allergic Aspergillosis in a Family

BY VICHARN VITHAYASAI, M.D., JOHN S. HYDE, M.D. and LOURDES FLORO, M.D./CHICAGO

AN association between asthma and aspergillosis was noted in 1925 by Van Leeuwen. In 1959, Pepys confirmed this by finding aspergillus species more commonly in the sputum of patients with asthma than with other lung disease. Manifestations are recurrence of coughing, fever, transient lung infiltrations, and eosinophilia. Also, they described bronchial plugging by viscid secretions containing *Aspergillus fumigatus*. These same authors demonstrated precipitating antibodies to *Aspergillus fumigatus* extracts.

Hinson and associates described three types of pulmonary disease due to aspergillus in 1952:

Type I: In the saprophytic mycetoma, the aspergillus complicates some pre-existing pulmonary condition, for example bronchiectatic cyst, pulmonary infarct, or tuberculosis.

Type II: In allergic aspergillosis, sensitization to the fungus leads to the production of an exudate in the bronchial lumen consisting of mycelium together with mucus, fibrin and eosinophils.

Type III: In the septicemic variety, multiple mycotic abscesses or granulomata occur in the lungs and sometimes elsewhere. This is the most serious form of aspergillosis.

Case Reports

Three members of a family with asthma who developed pulmonary infiltrates during one month period were observed. This prompted us to investigate the possibility of allergic aspergillosis.

Patient I: A 12-year-old white male, developed perennial asthma at age six years. At the onset of his acute illness he had fever of 102°F, cough, chills, malaise, and wheezing. X-ray films of the chest revealed atelectasis and infiltrates of the posterior basilar segment of the left lower lobe. There was an associated mediastinal shift to the left. Hemogram: WBC - 8,200, HCT - 38.5, Hb. 13.4 gm% and differential: 77 polys, 15 lymphocytes, 4 monocytes and 4 eosinophils. He was treated with ampicillin. Repeat chest films five days later revealed clearing of the infiltration, but the atelectasis persisted. Chest films five months later were normal. PPD (5 T.U.) skin test was negative.

Patient II: Twelve days after the onset of illness in the first patient, a 13-year-old brother developed fever of 102°F, chills, cough, and malaise. He had perennial asthma since age four. CBC: WBC 8,200, HBg, 13.6 gm% Hb and differential count: 70 polys, 23 lymphocytes, 2 monocytes, and 5 eosinophils. Chest films revealed streaky infiltrate radiating from the right hilum into the right base, posteriorly and minimal segmental atelectasis in the right middle lobe. Hemophilus hemolyticus grew in the throat culture. His symptoms subsided after ten days treatment with ampicillin. Five days later regression of the infiltrates were noted. Also the thickening of the bronchial markings and the atelectasis at the right lung base were decreased after three weeks.

Patient III: The mother of the two boys, age 40, a nurse, had seasonal asthma beginning at the age of four. A pre-employment radiograph of



Vithayasai

Hyde

Floro

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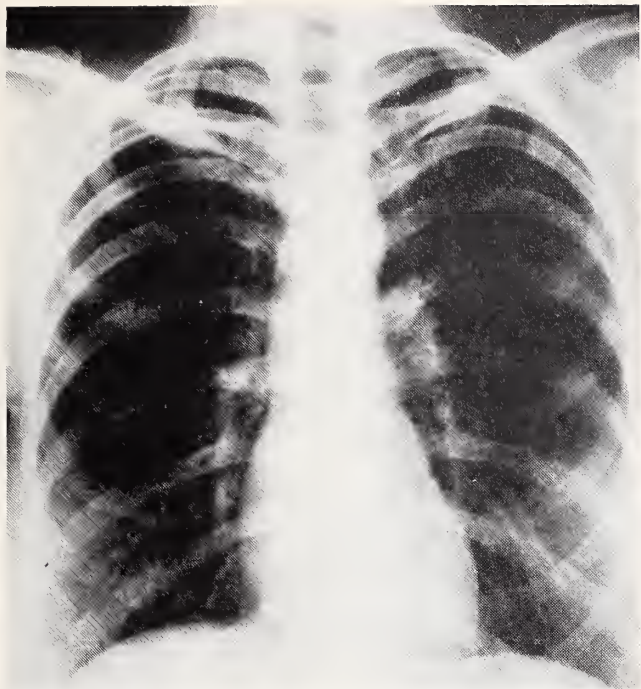


Fig. 1. 3/23/68. Pre-employment radiograph of chest was considered normal.

the chest was normal, (Fig. 1). One month after the onset of pneumonitis in the first patient, she developed fever of 101°-103°F, cough, chills, muscle pains, shortness of breath and moderate dyspnea. On the third day of illness she expectorated bloody sputum. Chest films, (Fig. 2) revealed prominent right hilar markings extending toward the periphery, the lower portion of the right upper lobe was mottled with distinct infiltrates having hazy margins and without confluence. She was treated with ampicillin. Five weeks before the onset of her illness, she worked with fresh potting soil for her African violets. These were kept on the window ledge over the kitchen sink. Repeat chest film one week later, revealed increasing nodular densities in the right upper lobe and an ill defined nodular density in the left upper lobe. Again, the superior aspect of right hilum appeared to be definitely prominent. Persistent radiograph findings were noted four months later, (Fig. 3); becoming stable 14 months later, (Fig. 4) and remaining stable two years later (Fig. 5). During the acute illness ten pounds weight loss was recorded. Hemogram on April 8, 1970, showed: WBC 9,000, HbG, 14.4 gm.% Hb, Hct, 43% and a differential count of 74 polymorphs, 19 lymphocytes, six eosinophils, and one monocyte. Alpha₁ antitrypsin was 310 mg% by electroimmuno diffusion. B₁C level was 80 mg%.

Skin test to first and second strength PPD; coccidioidin, histoplasmin, and blastomycosis



Fig. 2. 4/22/70. Radiograph after onset of febrile illness. Patchy and confluent alvolar exudative process in the posterior segments of the right upper lobe. Unchanged since original study of 4/8/70.

were negative. Skin tests with common inhalant antigens revealed marked reaction to ragweeds, trees, housedust and airborne molds as well as to *Aspergillus fumigatus*. Four hours after the *Aspergillus fumigatus* intradermal test, the test site had 8 mm induration surrounded by definite edema and erythema. Immunodiffusion tests of the sera of the three patients demonstrated definite precipitin bands with *Aspergillus fumigatus* antigen. Colonies of *Aspergillus fumigatus* were isolated from Patient III sputum specimens during the first three months of illness. However, isoniazid was given because of a recent history of exposure to tuberculosis and the persistent infiltrates in chest films.

At three months B₁C globulin was 180 mg%. Eight months after the onset of her illness her symptoms had subsided and she felt well. Regional chest tomograms at the eleventh month demonstrated calcific, patchy densities without cavitation. Bronchogram of the right upper lobe revealed no bronchiectasis and no atelectasis. Unfortunately the remaining lobes could not be examined, since the patient had an adverse reaction to local anesthesia. Pulmonary function studies demonstrated mild obstruction of the airways, and a moderate increase in residual volume. Culture of bronchoscopic aspirate grew out a few colonies of penicillium and scotochro-



Fig. 3. 8/17/70. Changing appearance of the right upper lobe infiltration. Almost complete resolution of the inflammatory process.

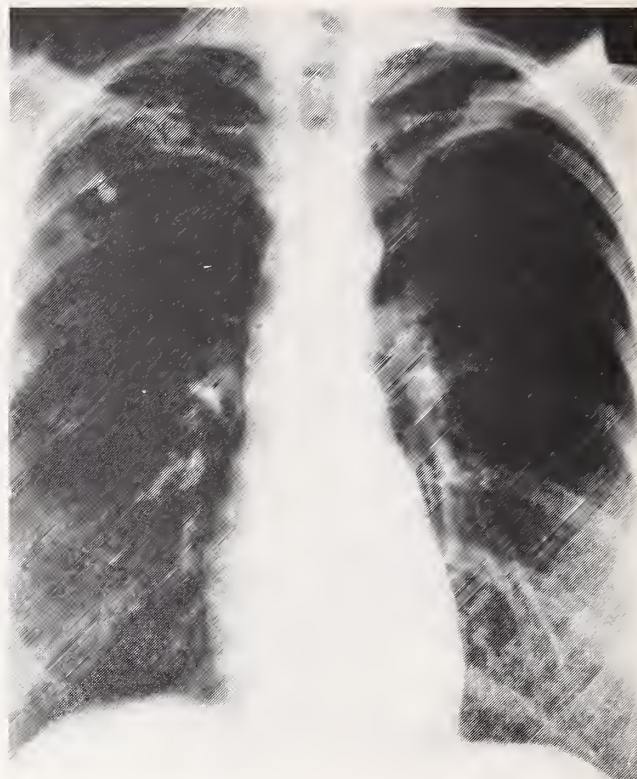


Fig. 4. 5/11/71. Nodular densities in the right upper lobe appear to be radiographically stable. These represent old post-inflammatory residues.

mogens.

By June 1971 a second strength PPD skin test was positive at 72 hours. Skin tests for atypical mycobacteria PPD-S (5 TU), PPD-B, PPD-G and PPD-Y were negative. CBC: WBC 9,600 with 81 polys, 16 lymphocytes, 1 eosinophils, and 1 mono. Absolute eosinophil count was 776 cells cmm.³ The three densities in the right upper lobe persisted and a small fibrotic density continued in the left upper lobe.

Discussion

The diagnosis of allergic pulmonary aspergillosis in this family is based on the successive illness of three members of an atopic family during one month, manifested by cough, chills, fever, shortness of breath and dyspnea. Considered diagnostic were: transient pulmonary infiltration in two children; absolute blood eosinophilia; positive *Aspergillus fumigatus* in sputum and potted soil; positive precipitin bands with *Aspergillus* antigen; and a return of B₁C globulin to normal level after the acute episode; also, positive immediate and late (Arthus) skin reactions to *Aspergillus* antigen were considered diagnostic.

Patient III represented a different pattern from her children because of persistent right upper lobe nodular infiltrations. Although a definite pathologic diagnosis could not be deter-

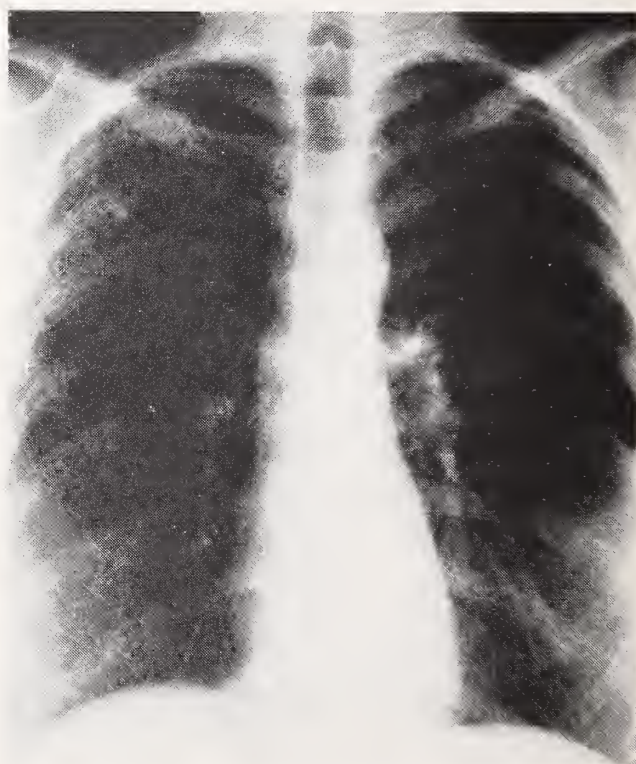
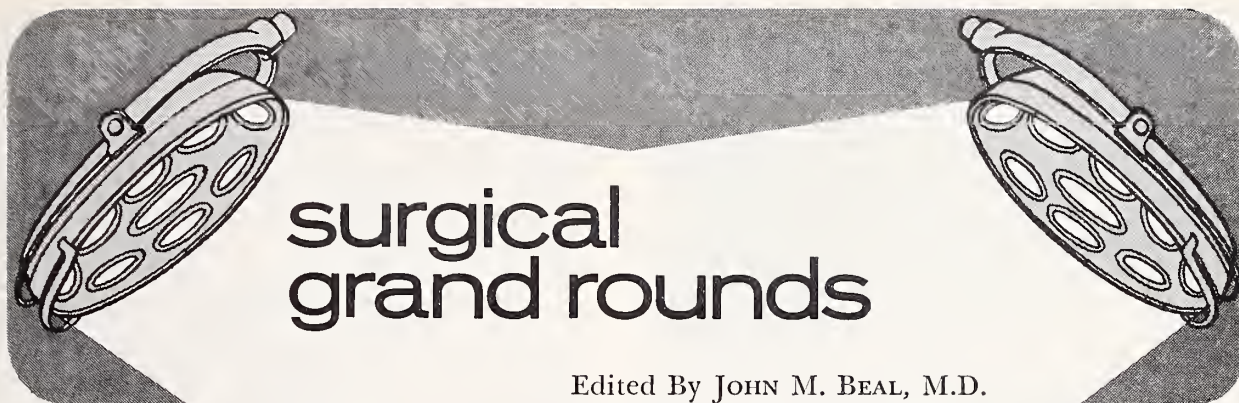


Fig. 5. 3/21/72. Unchanging, stable-appearing fibrocalcific and fibronodular lesions in right upper lobe.

(Continued on page 600)



Radiation Enteritis

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from the Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 22, 1973.

Dr. Charles Drucek: A 61-year-old white female was admitted to the hospital with cramping lower abdominal pain, bloating and vomiting. She had been treated by abdominal hysterectomy and bilateral salpingo-oophorectomy in October, 1971, for endometrial carcinoma. Pelvic irradiation was given in November and December, 1971, with a tumor dose of 6,000 rads through two converging ports, 12 x 15 centimeters each. She had an episode of severe cramping abdominal pain in April of 1972, which subsided spontaneously. This was followed by repeated attacks, becoming more frequent and more severe and associated with vomiting. In December of 1972, X-ray studies revealed evidence of a partial small bowel obstruction. Exploratory laparotomy was performed in January, at which time lysis of adhesions and a partial small bowel resection was required. Small bowel was found adherent to the left pelvic wall and an area of the bowel was necrotic. She had prolonged postoperative ileus, but finally tolerated the diet and was discharged, although some abdominal cramps persisted. The cramps became worse at home with bloating and then vomiting. Two weeks prior to admission X-ray studies were performed.

Dr. Leonid Calenoff: A barium enema examination shows a normal colon. Particularly there is no evidence of a lesion in the sigmoid colon. A barium meal small bowel examination shows dilated loops of jejunum and proximal ileum. There is an area of incomplete obstruction in-

volving a segment of distal ileum measuring approximately 10 cm. and located in the left iliac fossa (Figure 1). There is tapering of the involved area and considerable narrowing of the lumen. Some barium, however, bypasses the nar-



Figure 1. Radiologic study of the small bowel demonstrated dilatation with an area of incomplete obstruction in the left iliac fossa (arrows).

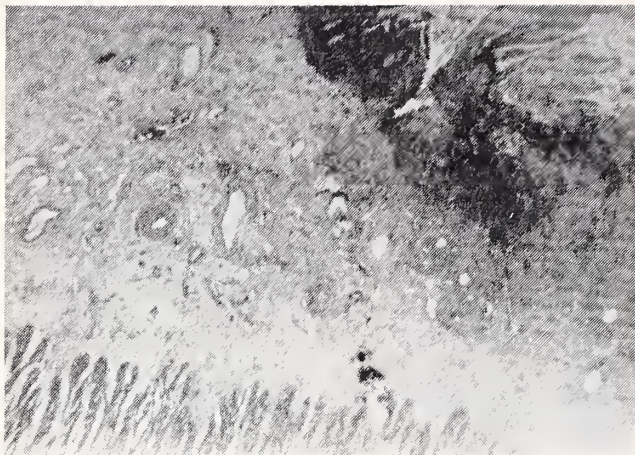


Figure 2. The section of ileum showed an ulcer of the small intestinal mucosa and fibrosis of the submucosa.

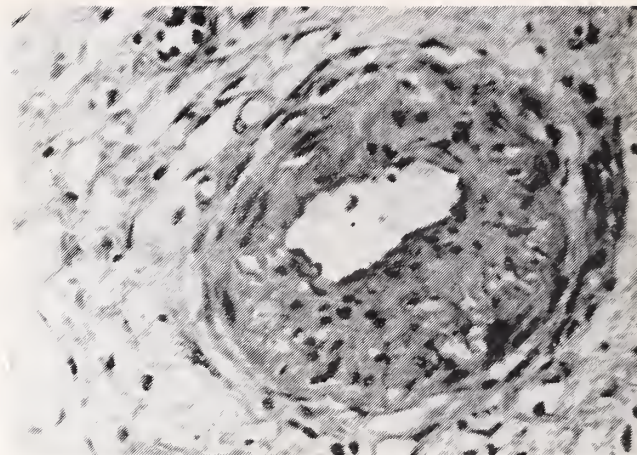


Figure 3. The intimal thickening of this small artery in the ileum is typical of radiation reaction.

row area and is seen in the distal ileum. This type of lesion can be found in ischemia of the bowel, granulomatous disease or radiation enteritis. In view of the patient's clinical course, the latter possibility is most likely.

Dr. Charles Drueck: Physical examination revealed evidence of a partial small bowel obstruction at the time of admission. Recto-vaginal examination revealed a shortened vagina and the rectum contained firm light brown stool without masses in the cul-de-sac. After preliminary fluid therapy, she was taken to the operating room. Numerous dilated loops of small bowel were encountered and an area which was not involved with either tumor or an adhesive band was edematous and necrotic although not ruptured. The cecum and terminal ileum were involved in a smiliar process and required resection.

Dr. Joseph Sherrick: In October, 1971, examination of the uterus showed a well differentiated adenocarcinoma of the endometrium which invaded the myometrium and appeared to invade vascular channels. The tumor did not extend to the serosal surface. The tumor showed a few areas of squamous metaplasia making it an adenocanthoma. In January, 1973, we received 34 cm of small intestine which showed numerous ulcers and had a thick wall with fibrous adhesions on the serosa. There was no evidence of tumor. (Figure 2) A section through one of the ulcers showed thick submucosa, contained blood vessels (Figure 3) with thickening of the intima which contained vasculated cells. In the thickened submucosa there were giant cells representing proliferating fibroblasts, which were first described in connection with radiation reaction by Gassman in 1898. These cells are large because the mitotic process is slowed by radiation while

other cell metabolic functions are normal, including that of cell growth. In April, 1973, we received two more portions of small intestine, 19 and 45 cm long, which showed ulceration, fibrosis, vascular changes and giant fibroblasts exactly like those seen in the first specimen. These changes are perfectly consistent with the diagnosis of radiation reaction of the intestine.

Dr. Charles Hughes: The effects of radiation may be placed in two general categories: immediate and late effects. The immediate effect on the epithelium of the mucosa is potentially reversible. The acute stage reaches its maximum about one month after treatment. As seen in this patient today, there may be a prolonged progressive, obliterative vasculitis and fibrosis which may become evident months or years later. The basic pathology involved in the prolonged or late type is endothelial proliferation, endoenteritis, subendothelial foam cell formation and fibrinoid degeneration in all layers of the bowel wall. The immediate or early changes will often result in nausea, vomiting and bloody diarrhea. Conservative management is usually effective.

The chronic radiation effects on the small bowel often present with partial or complete bowel obstruction. The patients may develop anorexia, malabsorption syndrome, megaloblastic anemia, paralytic ileus, perforation, fistula formation or even an intra-abdominal abscess. Chronic radiation complications have been reported as early as 8 months and as late as 31 years after irradiation therapy. Several etiologic factors have been implicated which enhance the occurrence of radiation effects on the small bowel. The presence of cardiovascular disease which produces lower cardiac output, occlusive arterial disease, hypertension, diabetes, or arteriosclerosis either

at the time of radiation or later in life, have been considered factors. Pelvic inflammatory disease causing adhesions in the pelvis contributes to radiation complications. The total dose of radiation is important. If the above mentioned etiologic factors are absent, the standard risk is between .5 and 1% that small bowel complications secondary to radiation therapy will occur. If there are fixed small loops, or pelvic inflammatory disease, the likelihood is 1 to 5%. It is likely that some patients have moderate bowel damage but have few symptoms. Radiation enteritis should be considered as a potential cause and abdominal pain in patients who have a history of radiation therapy to the pelvis or abdomen.

Dr. Franklin Lounsbury: This is a problem that is seen infrequently by surgeons. This patient has certain unique problems. The distressing aspect of the disease is the progressive nature of the inflammatory process. At the first operation we took out what we deemed was an adequate segment of small intestine, examined the rest of the bowel and saw no other areas that looked potentially dangerous. However, within two months, two areas of severe stenosis developed and another small area of complete necrosis necessitated removal of the additional areas. She is now able to eat again and have stools, but this is only three weeks since her second operation. We have no way of knowing whether she may have another episode of intestinal obstruction.

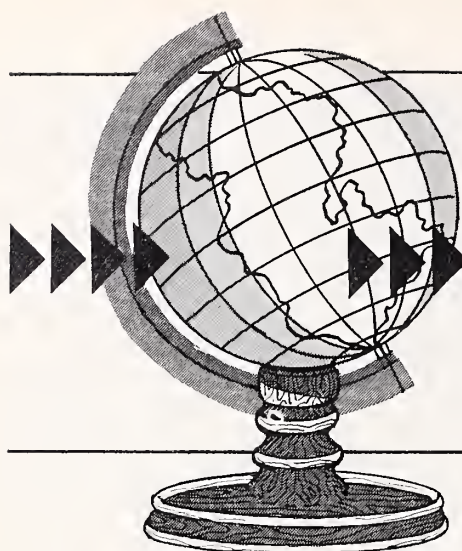
Dr. William Moss: I have been credited with a statement of doubtful value which goes something like, if postoperative radiotherapy is necessary, a preoperative radiotherapy should have been given. This is certainly true in many cases of carcinoma of the corpus where the only justification for giving the radiotherapy is in anticipation of clinically and surgically undetected disease at or beyond the line of surgical excision. And if the surgeon is going to transect cancer at that site, much better the radiation be given before cancer is spread throughout the peritoneal cavity than after. However, in a circumstance where, for one reason or another, a surgeon has performed such an operation and he questions the adequacy of his excision, there is little question what one should do. One should proceed with radiotherapy, often giving doses of a potentially curative level. Carcinoma of the corpus has a syndrome associated with it in which is recognized diabetes, hypertension and obesity. I don't know if this patient had any of these, but

the various aspects of this syndrome contribute to the post treatment complications of carcinoma of the corpus.

Anytime we are asked to see such a patient, we will usually question a surgeon and be guided by the operative findings. The pathologist may also provide information relative to the adequacy of excision. In any case, postoperative irradiation of a curative level is not to be undertaken lightly. The difference between external Co⁶⁰ and external cesium is one of differences in dose distribution. The depth dose from cesium is less and the skin dose is higher. It is ideal for cervical lymph nodes, but somewhat less so for a pelvic type treatment. Cesium delivers a high dose to tissues on each side of the deep pelvic structures to get the 6000 rads in the middle.

When should the bowel complication be considered due to recurrent cancer and when should it be considered a radiation effect? Is this recurrent cancer or is this a radiation complication? The treatment in the two circumstances would be different. We have seen a patient in which a judgement was made that the patient had residual cancer. The patient came to autopsy and post irradiation bowel obstruction was present. I think this possibility must be kept in mind. A third factor is appreciated when you realize that radiations damage cell multiplication. Anytime there is a problem which demands cell proliferation, the radiated tissue is less able to meet that demand than normal tissue. This is true whether that demand follows surgery or trauma. If one has to operate in a situation where radiation has been given, he must appreciate the fact that these cells will not proliferate to a normal degree. The tissues will not heal as well as tissues in a non-radiated volume. This may call for different techniques. In view of this it has been suggested that you bypass the obstruction rather than do an extensive resection. In fact, a resection in the presence of adhesions and poor tissue viability may create more problems than it solves. We can now predict with some confidence the high risk group—the aged patient, the patient with pelvic inflammatory disease, the patient with previous pelvic surgery, and even a cancer which has extended through the peritoneum to produce a bowel which is adherent in the pelvis. In these circumstances the bowel is treated every day and the dose to the bowel is high.

(Continued on page 604)



Medical Progress

Prevention of Accidental Falls in Infancy By Counseling Mothers

BY HARVEY KRAVITZ, M.D., MORTON GROVE

This article summarizes the results of a two-year study of falls from elevated surfaces in infancy in a suburban private pediatric practice.*

Methods

The infants in the first year of this study (1967) were part of a previous study reported in 1969.¹ This group of 336 infants served as a control group. The parents of this group received no special safety instructions on prevention of falls in infancy. This was called the uncounseled group. In the second year (1968) of the study, the parents of a second group of 320 infants received specific oral and written instructions in the dangers of falls in infancy. Signs were placed over every examining table in our offices to serve as a reminder to each mother during the infant's monthly visit about the danger of falls. (Figure 1) These infants served as the counseled or experimental group. The purpose of the study was to determine how effective

visual, oral and written instructions about preventing falls in infancy would be in reducing to a significant degree the number of falls in the first year of life.

There was no essential difference in the two groups of mothers as to socio-economic status, the character of the homes, the maternal age and the birth order of the children.

The data collected included the age of the infant at the time of the fall, the time of day or night the fall occurred, the type of injury and the object from which the infant fell. Data on the effect of ineffective design or equipment failure and the effect of human error as a cause of accidents were collected. Infants with orthopedic or neurologic diseases were excluded from the study. Falls occurring as the result of walking were excluded from the study. An accident report was recorded for each patient reported to have fallen. This was recorded as a prospective case. Reports of falls were recorded from birth to one year in both groups. After the end of each year of study, all the mothers of the infants in the uncounseled (control) and counseled (experimental) groups were called to determine whether other unreported falls had occurred. These were recorded as retrospective cases.

*This investigation was supported by a grant from the Mead Johnson Co., Evansville, Ind.

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Table 1
Number and Percentages of Accidental Falls
in Infants Under One Year of Age

Group	Number of infants	Falls prospective	Percent	Falls retrospective	Percent	Total falls	Percent
Uncounseled (Control)	336	58	17.2	43	12.1	101	30.0
Counseled (Experimental)	320	33	10.3	10	3.1	43	13.4
Total	$X^2=27.5$	$df=1$	$p<.001$				
Prospective	$X^2=6.7$	$df=1$	$p<.01$				
Retrospective	$X^2=20.8$	$df=1$	$p<.001$				

Results

The results are summarized in Tables 1-4. Table 1 shows the frequency and percentage of falls in both groups. The uncounseled group of 336 infants had a "first" fall rate of 30.0% or 101 falls, compared with 13.4% or 43 falls in 320 infants of the counseled group. The difference is statistically significant at the .001 level.

The falls in the counseled and the uncounseled groups were broken down into those cases seen prospectively and those cases found retrospectively. There were 58 falls (17.2%) in the prospective uncounseled group compared to 33 falls (10.3%) in the prospective counseled group. (Table 1) The difference is statistically significant at the .01 level.

There were 43 falls (12.2%) in the retrospective uncounseled group compared to 10 falls (3.1%) in the retrospective counseled group (Table 1). The difference is statistically significant at the .001 level.

One may assume that the parents were reluctant to report falls retrospectively in the counseled group after they were instructed in fall prevention. If this were so and the number of falls in the retrospective counseled group were corrected to give the same rates as in the uncounseled group the corrected number of falls in the retrospective group would be 24 and not 10. When the corrected figure of 57 of the total counseled group is compared to the total uncounseled group of 101, the difference is still statistically significant at the .01 level. ($X^2=13.4$)

One cannot assume that parents were reluctant to report accidents in the prospective data. Parents almost always call the doctor immediately after an infant falls, for emergency advice.

The mean age of the first falls in the uncounseled group was 7.2 months compared to 7.1 months in the counseled group. Falls were

infrequent below 5 months in both groups. The largest percentage of falls occurred between 5 through 10 months of age in both groups. Seventy percent of the falls occurred during this age period in the uncounseled group compared to 77% in the counseled group. The difference is not significant.

Falls occurred between the hours of 6:00 A.M. through 10:00 P.M. in both groups. The largest number of falls occurred at 11:00 A.M. and 5:00 P.M. in the uncounseled compared to 9:00 A.M., 11:00 A.M., and 7:00 P.M. in the counseled group.

Almost all of the injuries were head injuries. The type of injuries to the head are similar in both groups. Two fractures of the skull and one subdural hematoma were noted in the uncounseled group, while three fractures of the skull were reported in the counseled group.

There were hospitalizations for 4.9% of the uncounseled group for symptoms of lethargy, vomiting, unconsciousness and seizures compared to 11.6% in the counseled group.

Tables 2 and 3 show the effects of poor design of equipment and human error on first falls in both groups.

Leaving a child unattended in beds, chairs, couches and strollers constituted the largest background cause of "first falls." Climbing over the sides of the crib was the most common cause of falls in infancy. In the uncounseled group 20.5% infants fell out of cribs as compared to 11.9% in the counseled group. If falls from cribs are also considered human error, 77.2% of this type of human error occurred in the uncounseled group as compared to 70.0% in the counseled group. Falls from the hands of parents or siblings were infrequent in both groups.

Table 4 lists the object from which infants

Table II
Apparent Contribution of Poor Design of Equipment to "First Falls" in Infants

	Counseled Control Group		Counseled Experimental Group	
	N = 101	%	N = 43	%
Climbed over side of crib	21*	20.7	5	11.6
Crib side was not fastened	0	.0	2	1.9
Strap broke or slipped on dressing table	2	1.9	0	.0
Slid out from high chair (no strap)	2	1.9	1	.9
Infant rocked infant seat off table	4	7.6	0	.0
Fell out of stroller	2	1.9	3	7.0
No accident	70	66.0	32	78.6

*This cannot reasonably be treated as "human error" on the part of the infant, since the supervising adult would have to add a netting or other device to prevent the child's climbing out. The authors see this as a case of poor equipment design.

fell in both groups. The dressing table leads the list with 30.2% of the falls in the counseled group as compared to 27% in the uncounseled. Similar percentage of 22% from the uncounseled and 23.2% for the counseled group occurred from falls from adult beds. There were falls in 21% of the infants from cribs in the uncounseled group compared to only 11.6% in the counseled group.

Comments

1. There was a significant decrease in the percentage of falls in the counseled group compared to that of the uncounseled group. This suggests that extensive indoctrination of mothers with infants, in fall prevention, is effective. The decrease in falls in the experimental group was a general one with the exception of significantly fewer falls from cribs in the experimental group.

2. Very few multiple falls were observed in either group, suggesting that suburban mothers learn to control infant injury after an initial fall. These findings are in sharp contrast to the large number of multiple falls reported previously in clinic patients from a poor socioeconomic neighborhood.¹

3. Head injury was the most common type of injury in both groups. No fracture of the extremities, pelvic, vertebrae or intra-abdominal

injury, or evidence of multiple injury was recorded. No cases of child abuse were suspected or reported in our study.

4. Much more emphasis is needed in the education of mothers in accident prevention. Nurseries should have large signs of a permanent type inside the picture windows, warning about falls in infancy.

5. Doctor's offices and clinics should have similar signs over examining tables to be a constant reminder to the parents. Signs reminding doctors, nurses and parents about fall prevention have been placed in pediatric departments. Lowrey² states that over half of the accidents occurring in the pediatric wards are due to falls from cribs or beds.

6. Pediatricians and general practitioners caring for infants should give written information on fall prevention as a part of the going home instructions to each mother.

7. Manufacturers of infant furniture need to improve the design of cribs, dressing tables and infant seats. Climbing out of cribs could easily be avoided if the mattresses could be lowered closer to the floor. This could be done easily by having the ratchets extend closer to the floor. The use of netting and plastic bubble covers has been helpful in reducing falls. Infants have climbed out of cribs by standing on large blocks of toys. Infants have used bumper guards that

Table III
Apparent Contribution of Human Error to "First Falls" in Infants

	Uncounseled Control Group		Counseled Experimental Group	
	N = 101	%	N = 43	%
Infant slipped from adult's hands	2	1.9	1	2.3
Infant left unattended by mother on adult bed, chair, couch, stroller, etc.	66	65.4	30	70.0
Sibling left in attendance	2	1.9	2	4.6
No accident	31	30.8	10	33.1

Table 4
Object From Which Infant Fell

	Uncounseled Control Group		Counseled Experimental Group	
	N = 101	%	N = 43	%
Adult bed	22	21.8	10	23.2
Couch	7	6.9	1	2.4
Infant dressing table	27	26.7	13	30.2
Crib	21	20.8	5	11.6
High chair	5	4.9	1	2.4
Kitchen table	3	3.0	0	.0
Adult chair	5	4.9	1	2.4
Infant seat	4	4.0	2	4.7
Mother's arms	2	2.0	1	2.4
Sibling's arms	1	1.0	2	4.7
Stroller	3	3.0	4	9.4
Toilet	1	1.0	0	.0
Examining table at office	0	0.0	1	2.4
Car seat	0	0.0	1	2.4
Swing	0	0.0	1	2.4

are square on top to climb out of cribs. Tapering the bumper guards or removing them when a child first attempts to climb, could eliminate this type of fall. The use of thick sponge rubber rugs around cribs could soften falls. Infant dressing tables could be improved by having a concave surface instead of a flat surface. Lowering the height and adding a small rail could further reduce falls from dressing tables. Im-

provements in the design of infant seats also are needed to prevent infants from pushing or rocking them off table tops. ◀

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Clinics for Crippled Children Listed for January

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Jan. 2	Hinsdale—Hinsdale Sanitarium	Jan. 11	Chicago Heights Cardiac—St. James Hospital
Jan. 3	Sterling—Sterling Community Hospital	Jan. 14	Peoria Cardiac—St. Francis Children's Hospital
Jan. 3	Lake County Cardiac—Victory Memorial Hospital	Jan. 15	Mt. Vernon—Park Avenue Baptist Church
Jan. 8	Peoria—St. Francis Children's Hospital	Jan. 15	Rock Island—Moline Public Hospital
Jan. 8	E. St. Louis—Christian Welfare Hospital	Jan. 15	Decatur—Decatur Memorial Hospital
Jan. 9	Champaign-Urbana—McKinley Hospital	Jan. 16	Springfield Pediatric Neurological—Diocesan Center
Jan. 9	Joliet—St. Joseph's Hospital	Jan. 16	Evergreen Park—Little Company of Mary Hospital
Jan. 10	Effingham—St. Anthony Memorial Hospital	Jan. 17	Rockford—Rockford Memorial Hospital
Jan. 10	Springfield—St. John's Hospital	Jan. 17	Elmhurst Cardiac—Memorial Hospital of DuPage County
Jan. 10	Cairo—Public Health Department	Jan. 22	Peoria—St. Francis Children's Hospital
Jan. 10	Macomb—McDonough District Hospital	Jan. 23	Centralia—St. Mary's Hospital
		Jan. 23	Chicago Heights General—St. James Hospital
		Jan. 25	Chicago Heights Cardiac—St. James Hospital
		Jan. 28	Peoria Cardiac—St. Francis Children's Hospital

Visceral Larva Migrants

BY PAUL J. HLETKO, M.D., CHANDU PATEL, M.D., AND RUTH ANDREA SEELER, M.D./CHICAGO

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Often children are admitted to the hospital for diagnosis and therapy of one condition and then found to have another related problem. A recent child with pica is an especially interesting example of this phenomenon.

Case Report

A 27-month-old female was referred by the Chicago Board of Health to the Cook County Hospital, Division of Pediatrics, for therapy of a whole blood lead level of 92 micrograms % found during a routine screening program. A repeat whole blood lead level of 136 micrograms percent confirmed the diagnosis of asymptomatic plumbism. The child had a history of pica for "everything". Physical examination revealed a palpable liver 1 cm below the right costal margin and mild cervical and inguinal lymphadenopathy. No skin lesions or respiratory symptoms were present.

The initial CBC revealed a profound eosinophilia, 38%, with a total WBC of 20,200. On two subsequent blood counts, the percentage of eosinophils ranged from 36% to 42% with a total WBC around 12,000/mm³. Thus, the absolute eosinophil counts ranged from 4,304 to 8,360/mm³.

Because of the history of pica and the extreme degree of eosinophilia, the diagnosis of visceral larva migrants was considered¹⁻⁵. Additional history revealed that the child had extensive intimate contact with cats and kittens. The total

protein was 7.2 grams% with an albumin of 3.6 and a globulin of 3.6 grams percent. The immunoglobulins revealed a normal IgG of 720 mgs.% and an elevated IgA of 95 mgs% and IgM of 220 mgs%. The child is of blood group A and the anti-B titer was 1:1024 (normal less than 1:64). The tests of liver function revealed a SGOT 59 and SGPT 301 with the alkaline phosphatase of 84 BLB units. Stools for ova and parasites were negative on multiple occasions.

The patient received a course of BAL and EDTA therapy and is currently followed in our outpatient department. The eosinophilia had resolved by six weeks and the other biochemical abnormalities were returning to normal.

Discussion

In any patient with eosinophilia, it should be established that true eosinophilia exists. Laboratory recording error or poor staining technique may be eliminated by repeat examination of the peripheral blood film. The Pelger-Huët phenomenon could possibly be confused with eosinophils by the inexperienced observer as the polys are undersegmented.

Having established that true eosinophilia exists, one can classify eosinophilia into a hereditary and acquired form. The uncommon, but easily diagnosed, familial eosinophilia is established by the presence of eosinophilia in multiple family members over a prolonged period of time. Having eliminated this familial type, eosinophi-

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lia is usually considered in two broad categories: moderate 10-40%, and exaggerated, over 40%⁴.

Most causes of moderate eosinophilia can be diagnosed by history, physical examination plus the usual laboratory tests⁴. The differential diagnosis includes:

- Drug related eosinophilia
- Hodgkin's Disease
- Fanconi's anemia
- Hemolytic uremic syndrome
- Myeloproliferative disorders
- Collagen diseases
- Atopic dermatoses
- Cirrhosis
- Radiation reactions
- Eosinophilic pneumonia
- Parasitic infections

Most causes of moderate eosinophilia are readily recognized as a complication of, or part of, another disease process.

Exaggerated eosinophilia may simply represent one of the moderate eosinophilic syndromes or eosinophilic leukemia or idiopathic hyper-eosinophilic syndrome. Parasitic infections, frequently asymptomatic, may cause moderate to exaggerated eosinophilia. The parasitic diseases should not be abandoned when the stools are found negative for ova and parasites and the chest X-ray is normal.

Our patient was initially admitted because her pica had led to the diagnosis of asymptomatic plumbism. In addition, she was found to have another problem resulting from pica, namely, visceral larva migrans. In any child with a strong history of pica and significant eosinophilia, one should be very suspicious of ingestion of parasites from soil, domestic pet excreta, infested meats, etc. as the etiology for the eosinophilia.

Visceral larva migrans is a systemic disease resulting from ingestion of *Toxocara canis* and *Toxocara cati* parasites inhabiting the gastrointestinal tract of many household cats and dogs. These children are frequently asymptomatic and the only suggestion of the disease is found when a routine CBC reveals a striking absolute eosinophilia. Careful history, physical examination, and laboratory evaluation may reveal multiple organ system involvement⁵:

1. Pulmonary-cough, wheeze, dyspnea, diffuse radiographic abnormalities.
2. Myocarditis
3. Hepatic-abnormal liver tests \pm hepato-

megaly

4. Central nervous system—Meningitis, encephalitis, seizures.
5. Ocular granulomas
6. Cutaneous—macular papular rash, urticaria, erythema nodosum.
7. Miscellaneous — pancreas, kidney, G.I. tract, lymphatics.

Particularly helpful laboratory determinations include the striking elevation of the isohemagglutinins from a normal range of 1:32 to 1:64 to in excess of 1:512.³

Additional laboratory abnormalities include the profound eosinophilia and a significant hyperglobulinemia. When parasitic infection is particularly heavy, other organ systems may be involved with corresponding laboratory abnormalities. In our patient there was biochemical evidence for mild hepatic involvement in addition to the striking eosinophilia, elevation of anti-B titer, and elevations of IgA and IgM immunoglobulins.

Asymptomatic and mild cases require no specific therapy for the child as is seen in our patient. However, the source of the parasites should be eliminated by having the pets dewormed. Severe parasitic infestation may require supportive treatment for the organ system which appears significantly compromised. Several medications have been used in attempts to destroy the parasite of which thiabendazole would appear to be the most efficacious. Diethylcarbamazine and steroids have been used with questionable results⁵. ◀

Acknowledgement

The authors wish to thank Mr. Oscar Behzad of the Cook County Hospital Blood Bank for performing the anti-B titers.

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Measles In Suburban Cook County

By COLETTE M. RASMUSSEN, M.D., M.P.H. AND R. JAMES MULROONEY, B.A.

During the first six months of calendar year 1972, over 500 cases of measles were reported to the Cook County Health Department. Because many private physicians were seeing measles in supposedly immunized youngsters, measles vaccine failure was suspected and a careful investigation was done concerning the immunization history of each case.

Locality:

The Cook County Health Department's jurisdiction covers nearly 2 million persons in 123 incorporated communities and unincorporated areas of suburban Cook County. There are about 500,000 students distributed in about 900 schools. School nurses are employed by school districts and not by the health department. There are 17 hospitals and about 3,000 physicians in the area.

The entire socio-economic spectrum is represented, from among the poorest to the wealthiest communities in Illinois.

Reporting:

Illinois law¹ states "It shall be the duty of every physician, dentist, other practitioner, attendant, nurse, laboratory, parent, householder, school authority, or any other person having knowledge of a known or suspected case of communicable disease or communicable disease death, to report promptly. . . ."

In spite of this law the reporting of communicable diseases, especially the common ones, is very poor. Measles is no exception. Nevertheless it is felt that changes in the number of reported cases of measles are a true reflection of actual incidence in the community.

Table 1 shows the drop in reported cases after measles vaccine came into common use, the rise in 70-71, and the dramatic increase in the first six months of 1972.

The health department has a close working

relationship with nurses in the elementary schools which is reflected in the fact that 73.1% of the total number of reported cases occurred in grade school children and that 71.3% of the total number of cases was reported by school nurses. (See Table 2.)

During the outbreak, reports were received from parents, doctors, hospitals, and school nurses. In addition, certain schools were visited and absentee records obtained. During investigations of a case, reports of other cases in the same family or in the neighborhood were elicited. These are included in the "other" category on Table 2. Duplicate reports were eliminated.

Cases were reported from all areas of the coun-

TABLE 1
Measles Cases Reported To Cook County Health Department

Year	No. of Cases
1958	4253
1959	1094
1960	7822
1961	1665
1962	5459
1963	693
1964	2394
1965	417
1966	749
1967	41
1968	2
1969	16
1970	78
1971	187
1972 (to June 12th)	505
January	11
February	6
March	23
April	81
May	264
June (to 12th)	120

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TABLE 2
Source of Report—400 Measles Cases

Age Group	REPORTED BY			Totals
	Physician	School	Other	
Pre-school (9.3%)	18 or 48.6%	1 or 2.7%	18 or 48.6%	37
Grade School (73.1%)	36 or 12.4%	226 or 77.3%	30 or 10.3%	292
Jr. High School (14.3%)	4 or 6.9%	49 or 84.4%	5 or 8.6%	58
High School (2.8%)	0	8 or 72.8%	3 or 27.2%	11
Adult (0.5%)	1 or 50.0%	1 or 50.0%	0	2
TOTALS	59 (14.7% of total)	285 (71.3% of total)	56 (14.0% of total)	400

ty. Nearly all towns with a population of over 25,000 had some cases. The largest concentration was in the northern suburbs. These are the wealthiest areas. A greater percent of children are taken to their physician for childhood diseases, and there are more nurses in the school systems than in other parts of the county. These two facts may account for better reporting from this area. Nevertheless it is hard to understand why this area had so many unimmunized children.

Method:

The investigators focused on confirmation of the diagnosis of measles, and on the possibility of measles vaccine failure.

There were 505 confirmed measles cases reported from January, 1972, to June 12, 1972. The closing of schools, which resulted in the loss of the major source of reports, dictated the cut-off date. Confirmation of measles disease was made on the basis of telephone interview of the parent and/or physician. Table 3 lists the questions used during the diagnosis part of the interviews.

A full measles immunization history was obtained on 400 of these 505 cases (79%). Immunization information was elicited from school and medical records, by telephone interviews with parents, doctors, doctors' nurses and school nurses.

Results:

Table 4 shows a breakdown of the immunization histories by age of case. In each age grouping, the vast majority of the cases had not had measles vaccine; 61.5% of all cases had not had any vaccine. The next largest group, 24.8%, had received measles vaccine before the age of one. Nearly all of these cases occurred in grade school

children. At the time these children were infants, the administration of measles vaccine as early as nine months of age was acceptable practice. When several children in a household had the disease, the mother frequently mentioned that the child who had received measles vaccine under the age of one had a milder case than a sibling who had received no vaccine.

Live measles vaccine with gamma globulin had been received by 6.2% of the cases. A total of 18 cases, mostly in the junior high school, had received killed measles vaccine. The smallest group of all, 3%, gave a history of having received live measles vaccine without gamma globulin at age one or older.

Clinical Comments:

At the beginning of the outbreak many different diagnoses were made by parents and physicians who assumed that the child was immune to measles. The prodromal symptoms were often so severe that children were taken to hospital emergency departments. Some were admitted only to be discharged three days later when the rash erupted. Several children were so severely ill that hospitalization for pulmonary symptoms was necessary during the later part of the illness.

One death due to measles was found on death certificate review. This was a 14-month-old white female who became ill with fever and respiratory symptoms. A few days later the typical morbilliform rash appeared. She became progressively worse and was admitted to a hospital in a comatose state. She died soon after admission. Autopsy was refused by the family.

Two weeks before this child became ill, her older sister had been diagnosed as having measles. Neither child had received measles vaccine, nor had gamma globulin been used upon exposure.

TABLE 3

Questionnaire Used To Confirm Measles Diagnosis

Was patient seen by a physician? (yes) (no)

1. Fever _____ degrees

2. Duration of rash _____ days

3. Koplik Spots (yes) (no)

4. Cough (yes) (no)

5. Runny Nose (yes) (no)

6. Red or Runny Eyes (yes) (no)

7. Rubella Hi Test (pos) (neg) (not done)

8. Other specify _____

In opinion of investigator: (case) (not a case)

Comments: _____

Probable source of infection _____

TABLE 4
Immunization History—400 Measles Cases

Age Grouping	No Vaccine	LMV < 1 yr.	LMV with GG	Killed	LMV > 1 yr.	Totals
Pre-school (9.3%)	24 or 65.0%	6 or 16.2%	4 or 10.7%	0	3 or 8.1%	37
Grade School (73.1%)	160 or 54.9%	90 or 30.7%	21 or 7.2%	12 or 4.1%	9 or 3.1%	292
Jr. High (14.3%)	49 or 84.6%	3 or 5.2%	0	6 or 10.3%	0	58
High School (2.8%)	11 or 100%	0	0	0	0	11
Adult (0.5%)	2 or 100%	0	0	0	0	2
TOTALS	246 (61.5% of total)	99 (24.8% of total)	25 (6.2% of total)	18 (4.5% of total)	12 (3% of total)	400

Discussion

Prior reports of measles outbreaks in Illinois due to lack of immunization of school children have been published.² Illinois has had a school immunization law³ requiring measles immunization before entrance to school. It was surprising, therefore, that 60% of the school cases had not had any measles vaccine. Visits were made to check health records and interview school nurses⁴ to learn why this occurred. We found many records had been improperly filled out by the physician and poorly checked by the school nurses. Immunizations were of low priority to many school administrators; hence nurses had no help in checking records and in following through on unimmunized students.

Checking with families we found that in many cases the mother was under the impression that the child had had measles, and therefore did not need the vaccine. Other mothers confused measles vaccine with rubella vaccine.

Many times the investigators were told that the child had missed getting his immunization because of illness. No follow-up had been done despite subsequent visits to a physician. Many families had moved, lost records, and changed physicians. Mobility appears to be a factor in the lack of immunization in middle-class children.

Prevention:

Efforts to prevent measles are mainly centered on dissemination of information learned during this outbreak. Points to be emphasized are:

1. Parents must be educated about the importance of measles immunization. Availability of free clinics for those who cannot

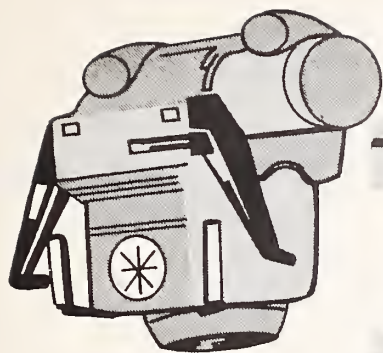
afford a private physician must be publicized.

2. All children should receive live measles vaccine without gamma globulin as soon as possible after their first birthday.
3. Children who received a less desirable regimen (under a year of age, or killed vaccine, or vaccine with gamma globulin) should be immunized.
4. Children with doubtful histories of having had the disease or the vaccine should receive the vaccine.
5. A child who misses his scheduled immunization because of intercurrent illness should be followed and immunized as soon as possible.
6. Susceptible children exposed to measles disease should be protected with gamma globulin and recalled for active immunization in 2-3 months.
7. Schools must give a higher priority to checking immunization records and following up on unimmunized students.
8. Better reporting must be stimulated so that immediate coverage of susceptibles with vaccine can be undertaken, thus localizing outbreaks.

Summary

In the spring of 1972, a large outbreak of measles occurred in suburban Cook County with over 500 confirmed cases reported to the health department.

Of the 400 cases which were completely investigated, only 3% had had measles vaccine administered according to current recommendations—live vaccine, administered without gamma globulin, at one year of age or older. This is a low
(Continued on page 605)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Figure 1

The patient is a 33-year-old psychotic female who during the course of her hospitalization began to vomit. Previous history includes surgery for a duodenal ulcer. What's your diagnosis?

1. Pancreatitis
2. Gas Producing Left Perinephric Abscess
3. Foreign Bodies
4. Splenic Abscess

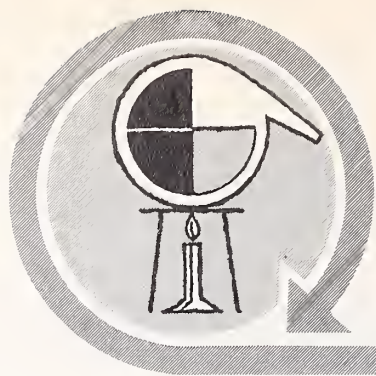
(Answer on page 604)



Figure 2



Figure 3



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

ALUPENT Bronchodilator R

Manufacturer: Boehringer Ingelheim Ltd.

Nonproprietary Name: Metaproterenol Sulfate

Indications: Bronchial asthma and reversible bronchospasm.

Contraindications: Cardiac arrhythmia with tachycardia.

Precautions: Use extreme caution with additional sympathomimetic agents.

Dosage: Two to three inhalations every three to four hours. Total daily inhalations not to exceed twelve.

Supplied: Metered dose inhaler 225 mg.

ANCET Broad Spectrum Antibiotic R

Manufacturer: Smith Kline & French Laboratories

Nonproprietary Name: Cefazolin Sodium

Indications: Infections due to susceptible organisms of the respiratory and genitourinary tract, skin and soft tissue, bone and joint, septicemia and endocarditis.

Contraindications: Patients with known allergy to cephalosporins.

Precautions: Use with caution in patients allergic to penicillin.

Dosage: Follow instructions of package insert.

Supplied: Vials, 250, 500 and 1,000 mg.

MARCAINE Anesthetic-Local R

Manufacturer: Winthrop Laboratories

Nonproprietary Name: Bupivacaine

Indications: Peripheral nerve block, infiltration, sympathetic block, caudal, or epidural block.

Precautions: Those usual with local anesthetics.

Dosage: See package insert.

Supplied: Vials and ampules 50 cc.

0.25, 0.5 and 0.75% solution.

With and without epinephrine.

DUPLICATE SINGLE DRUGS

FASTIN Antiobesity Preparation R

Manufacturer: Beecham-Massengill Pharmaceuticals.

Nonproprietary Name: Phentermine HCl.

Indications: Management of exogenous obesity, short-term therapy.

Contraindications: Advanced arteriosclerosis, symptomatic cardiovascular disease, hyperthyroidism, glaucoma and hypersensitivity to the drug.

Precautions: Tolerance may develop within a few weeks.

Dosage: One capsule two hours after breakfast.

Supplied: Capsules, 30 mg.

FLUROBATE GEL Topical Corticosteroid R

Manufacturer: Texas Pharmacal Company.

Nonproprietary Name: Betamethasone Benzoate.

Indications: Symptomatic relief of inflammatory manifestations of the skin.

Contraindications: Varicella and vaccinia, not for ophthalmic use. Hypersensitivity to corticosteroids.

Precautions: See package insert.

Dosage: Apply to affected areas 2 to 4 times daily as needed.

Supplied: Tubes 15 and 60 gm.; 0.025%.

GASTRIX Antispasmodic R

Manufacturer: Rowell Laboratories, Inc.

Nonproprietary Name: Oxyphenyclimine HCl.

Indications: To control symptoms due to hypersecretion and hypermotility of the gastrointestinal tract.

Contraindications: Glaucoma, advanced renal and hepatic disease and other conditions contraindicated to anticholinergics.

Dosage: 1 tablet t.i.d.; in the morning and before retiring; adjust to patients' response.

Supplied: Tablets, 10 mg.

COMBINATION PRODUCTS

BLEPHAMIDE S.O.P.

OPHTHALMIC Steroid-Sulfonamide o.t.c.

Manufacturer: Allergan Pharmaceuticals

Composition: Sod. Sulfacetamide 10%
Prednisolone Acetate 0.2%

Indications: Bacterial infections of the eye.

Contraindications: Viral infections.

Cautions: Ophthalmic ointments may retard corneal healing.

Dosage: Apply small amount of ointment t.i.d. or q.i.d. and once or twice at night.

Supplied: Tubes, 3.5 gm.

SEBUTONE CREAM Therapeutic Tar Shampoo o.t.c.

Manufacturer: Westwood Pharmaceuticals, Inc.

Composition: Coal Tar 0.5%
Sulfur, micropulverized 2%
Salicylic Acid 2%
Wetting Agents
Lanolin

Indications: Resistant seborrhea, scalp psoriasis, and itchy scalp.

Administration: Massage liberal amount into wet scalp; use daily or every other day, depending on response.

Supplied: Tubes 4 ozs. cream.

NEW DOSAGE FORMS

GUIDE Injection Atraxic R

Manufacturer: Dow Pharmaceuticals.

Nonproprietary Name: Piperacetazine.

Indications: Acute psychotic disorders.

Precautions: Those applying to phenothiazine tranquilizers.

Dosage: For control acute symptoms: 2 mg. i.m. If uncontrolled: 2 or 4 mg. one hour later. Subsequent administration at 3 to 4 hours intervals. Each dose should not exceed 8 mg.

Supplied: Vials 10 cc., 2 mg./cc.

Doctor's News

PHYSICIANS' HELP NEEDED FOR CORONARY PREVENTION TRIAL—The medical profession is being asked to help resolve the cholesterol-coronary question. It is well known that people with high serum cholesterol levels are at high risk for developing coronary artery disease. The important question is *can "coronaries" be prevented by lowering the serum cholesterol?*

Patients are needed to help settle this important question. Physicians can help by referring patients with high cholesterol levels to the Washington University Lipid Research Center in St. Louis, Mo. The criteria for referral are as follows: elevated cholesterol; men, aged 35-59 years; and no manifest coronary artery disease.

Patients will remain under the primary care of their own physicians; the doctor-patient relationship will be scrupulously respected; there will be no cost to patients for any tests or drugs. Call Drs. Schonfeld or Witztum at (314) 454-3162 or write the Lipid Research Center, Washington University School of Medicine, Box 8046, 4566 Scott Avenue, St. Louis, Mo. 63110.

PHASE IV REGULATIONS LIMIT PHYSICIANS—Physicians, dentists and other practitioners are limited to an annual aggregate fee increase of 4%. The new limit is higher than the 2.5% mandatory limit on practitioners since 1971. No fee under \$10.00 can be increased by more than \$1.00 in a single year, and no fee over \$10.00 can be raised more than 10%.

NUTRITION SURVEY SLATED FOR DOWNSTATE—The U.S. Health and Nutrition Examination Survey of the Public Health Service will shortly be conducting operations in Madison and St. Clair Counties, Illinois. The initial phase will begin on February 11, with interviews from the U.S. Bureau of the Census calling on selected households in the sample area to obtain certain demographic information about each household and the individuals who live in them. Following this, approximately 383 persons between the ages of 1 and 74 years will be selected by a statistical sampling process to participate in the examinations. Examinations will be conducted during the period February 28 through March 26, 1974, in the survey's mobile examination center.

The survey has a dual purpose—to measure the nutritional status of the United States population between the ages of 1 and 74, and to obtain information on the health status and medical care needs of persons between 25 and 74 years of age. The examination is designed primarily to collect statistical data on health and medical care needs and nutritional status. Results of the examination are not disclosed to the examinee, but a report of findings of the examination is sent to the person's physician and dentist upon request.

Previous surveys, as part of the PHS and CDC program, have included other portions of Illinois.

LIVE TELEVISION SYMPOSIUM ON BRONCHITIS—An international, live television symposium on bronchitis, originating from London, England, will be aired at 2 p.m., Wednesday, January 30, 1974, at the Drake Hotel, Chicago.

The symposium is sponsored by the American College of Chest Physicians and Pfizer Laboratories. John Sharp, M.D., FACC, is chairman for the Chicago reviewing of the symposium. A question and answer period and a reception will follow the live broadcast. For further information contact Dr. Sharp at Hines VA Hospital.

OPHTHALMOLOGISTS PUBLISH LEARNING DISABILITIES POSITION PAPER—The Board of Directors and the Committee on Learning Disabilities of the Illinois Association of Ophthalmology has published a position paper on learning disabilities. Copies of the publication can be obtained from the IAO headquarters, 360 N. Michigan Ave., Suite 2010, Chicago 60601. The cost is 12c per copy.

HY GARNER MEMORIAL FUND ESTABLISHED—The Forest Hospital Foundation, Des Plaines, has established the Hy Garner Memorial Fund in honor of the late Harry H. Garner, M.D., Professor and Head of the Department of Psychiatry at the Chicago Medical School. The fund will make available a cash award for the next five years to the author of the best paper submitted by a psychiatric resident to the awards committee of the Illinois Psychiatric Society.

PHYSICIANS IN THE NEWS—C. Frederick Kittle, M.D., has been appointed Director of the Section of Thoracic Surgery at Rush-Presbyterian-St. Luke's Medical Center. Jeremiah Stamler, M.D., Chairman of the Northwestern University Medical School Department of Community Health and Preventive Medicine has been named the first Harry W. Dingman Professor of Cardiology.

New officers of the Central Neuropsychiatric Association are: Louis D. Boshes, M.D., President; Benjamin Jeffries, M.D., President-Elect; Lewis Barbato, M.D., Vice President; David W. Sprague, M.D., Secretary-Treasurer and Clarence Hoekstra, M.D., Counselor.

Illinois Physicians elected to the Board of Governors of the American College of Surgeons are: Charles E. Baldree, Jr., M.D., Belleville; Ward H. Eastman, M.D., Peoria; John H. Isaacs, Skokie; William A. Larmon, M.D., Chicago; Thomas W. McElin, M.D., Evanston; Edward F. Scanlon, M.D., Evanston; Burton J. Soboroff, M.D., Chicago and Harry W. Southwick, M.D., Chicago.

Peter E. Goschy, Chicago, is the new President of the Illinois Hospital Association. Goschy is President and Chief Executive Officer of Grant Hospital, Chicago.

Psychiatrist and Surgeon Honored

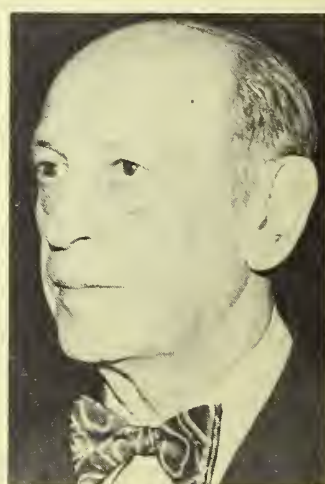
Roy R. Grinker, Sr., M.D., and Morris L. Parker, M.D., both of northside Chicago, recently were recipients of the first President's Medal for "contributions to the health and welfare of mankind" awarded by Michael Reese Medical Center.

Dr. Grinker, an internationally known psychiatrist, is a former student of Sigmund Freud. He is recognized for having advanced modern psychiatry's scientific standing and for enlisting other scientific disciplines in the study of human behavior. Dr. Grinker is founder of the Institute for Psychosomatic and Psychiatric Research and Training at Michael Reese.

Dr. Parker, a practicing surgeon at Michael Reese for more than 50 years, is known for his vast experience in the surgery of the GI and biliary tracts, thyroid, breast and hernia surgery, and his instigation of new surgical techniques.



Dr. Grinker



Dr. Parker



**Your experience has
shown you the benefits
of Lasix[®] (furosemide)
in initial therapy of
cardiac edema.**

Now...

(See prescribing information on last page of this ad.)

consider

LAAS

**(FUROSE
in long-term**



tablets
40mg

TM

X MIDE) therapy

- wide range of effectiveness allows you to treat most degrees of cardiac edema.
- dry weight can be reliably and safely maintained by adjusting the dose to fit your patient's needs. With doses exceeding 80 mg /day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.
- patient inconvenience is minimal since diuresis is usually complete within six to eight hours.

(See Lasix® [furosemide] prescribing information on last page of this ad.)

LASIX® (FUROSEMIDE)

TABLETS 40mg



in long-term therapy

WARNING—Lasix® (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities, the drug is contraindicated in women of child-bearing potential.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix, children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients. Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium depleting steroids.

Frequent serum electrolyte, CO₂ and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix.

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion.

In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

When parenteral use of Lasix precedes its oral use, it should be kept in mind that cases of reversible deafness and tinnitus following the injection

of Lasix (furosemide) have been reported. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic dose of 1 to 2 ampuls (20 to 40 mg).

Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose, and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour post-prandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites. It has been reported in the literature that diuretics such as furosemide may enhance the nephrotoxicity of cephaloridine. Therefore, Lasix and cephaloridine should not be administered simultaneously.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue Lasix for one week prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, erythema multiforme, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, light-headedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

DOSAGE AND ADMINISTRATION—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced.

If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). The dose of Lasix may be carefully titrated up to 600 mg per day in those patients with severe clinical edematous states. Higher doses are currently under investigation.

The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg/day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

Hypertension—The usual dose of Lasix is one tablet (40 mg) twice daily both for initiation of therapy and for maintenance. Careful observations for changes in blood pressure must be made when this compound is used with other antihypertensive drugs, especially during initial therapy. The dosage of other agents must be reduced by at least 50 percent as soon as Lasix is added to the regimen to prevent excessive drop in blood pressure. As the blood pressure falls under the potentiating effect of Lasix, a further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary. It is further recommended, if one tablet (40 mg) twice daily does not lead to a clinically satisfactory response, to add other hypotensive agents, e.g., reserpine, rather than to increase the dose of Lasix.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

HOW SUPPLIED—Lasix (furosemide) Tablets are supplied as white, monogrammed, scored tablets of 40 mg in amber bottles of 100 (FSN 6505-062-3336), 500, and Unit Dose 100's (20 strips of 5) (FSN 6505-117-5982). Note: Dispense in dark containers. Exposure to light may cause slight discoloration which, however, does not alter potency.

PRINTED IN U. S. A. 3-73

Start with— and stay with Lasix® (FUROSEMIDE)



HOECHST
PHARMACEUTICALS, INC.
SOMERVILLE, N.J. 08876



medical legal review

Diagnostic Patterns in Disability in Illinois and the Nation

BY HARRY E. GRANT, M.D., CHIEF MEDICAL CONSULTANT, ILLINOIS STATE AGENCY PROGRAM

This short statistical analysis of data compiled by the Social Security Administration shows the extent and nature of Illinois' participation in the Social Security Disability Program. It compares some of the State's data with national averages, and includes a comparison of worker disability allowances by diagnostic groups for Illinois and the U.S. overall.

Under the provisions of the Social Security Disability Program, the nation's largest disability plan, a worker under 65 can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted—or is expected to last—at least 12 months or is expected to result in death.

More than 96 million workers can count on monthly cash benefits in the event of such severe and extended disability. In addition, the dependents of these workers also are eligible for monthly benefits. Over 1.8 million workers and 1.4 million dependents are now receiving disability benefits at the rate of almost \$5 billion a year.

Currently, 73,825 disabled workers in Illinois are collecting \$13,842,701 a month in benefits. In addition, 10,463 wives or husbands of disabled workers and 35,541 children of disabled workers in Illinois are receiving \$635,544 and \$2,045,012 respectively.

The latest year for which tabulated data is available showing disabled worker diagnostic patterns by state is 1970. Disabled workers in

Illinois who began receiving benefits in that year constituted 15,974 of the 350,384 new beneficiaries nationwide.

Table 1 compares the frequently of diagnostic groups in Illinois with the U.S. overall. It shows that diseases of the circulatory system comprised the largest diagnostic group in the country in 1970. Diseases of the musculo-skeletal system and mental disorders, including psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. All states do not, however, follow this pattern.

Within these overall diagnostic groups, the most prevalent *primary diagnosis* in both Illinois and the nation in 1970 was chronic ischemic heart disease. Illinois recorded 2,540 cases that year. The nation's second most common primary diagnosis, schizophrenic disorders, accounted for 797 cases in Illinois. Following these, in order of decreasing national prevalence, was osteoarthritis and allied conditions, with Illinois reporting 560 cases, followed by emphysema with 656 cases. There were 435 cases of displacement of intervertebral disc in Illinois; 512 cases of diabetes

Table 1.—Social Security Worker Disability Allowances 1970—Diagnostic Groups

Diagnostic Group	U.S.		Illinois	
Diseases of the circulatory system	108,906	31.1%	5,032	31.5%
Diseases of the musculo-skeletal system	52,086	14.9%	1,872	11.7%
Mental, psychoneurotic, and personality disorders	38,406	11.0%	1,924	11.9%
Neoplasms	36,095	10.3%	1,750	11.0%
Accidents, poisonings, and violence	28,231	8.1%	1,130	7.1%
Diseases of the respiratory system	24,254	6.9%	933	5.8%
Diseases of the nervous system and sense organs	22,575	6.4%	1,095	6.9%
Allergic, endocrine system, metabolic, and nutritional diseases	13,141	3.8%	739	4.6%
Diseases of the digestive system	9,051	2.6%	619	3.9%
Infective and parasitic diseases	8,760	2.5%	525	3.3%
Other	8,875	2.5%	356	2.2%
*Total	350,384	100.0%	15,974	100.0%

*Figures may not total 100.0 due to rounding.

mellitus, and rheumatoid arthritis and allied conditions accounted for 383 cases in Illinois that year. Cerebrovascular disease, listed eighth among the most prevalent primary diagnoses in 1970, recorded 550 cases in Illinois; malignant neoplasm of trachea and lung 304 cases; and neuroses

ranked 10th with 184 cases.

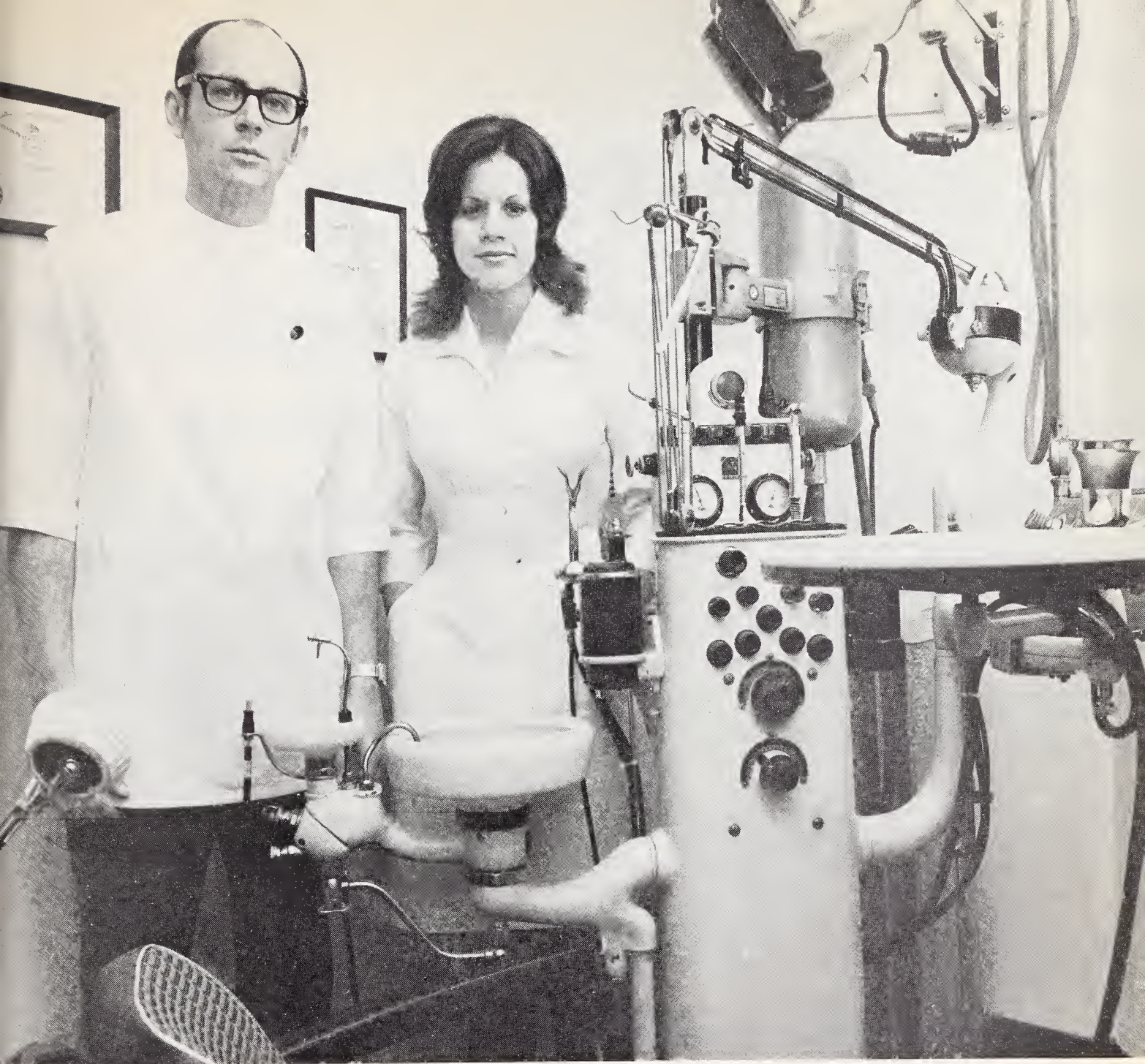
Additional information about the Social Security Disability Program in Illinois can be obtained through the Federal Disability Program, Post Office Box 3842, Springfield, IL. 62708; phone (217) 525-1520. ◀

Selby's Philosophy on Manuscripts

Clarence Selby was one of the most beloved industrial physicians of all time. His forte was leadership. Whatever he proposed, quickly he had an eager following. Clarence Selby had no outstanding capacities as a research investigator, but he sponsored much research. He was no formal teacher, but he had academic appointments and taught by example and experience. He was not an able writer, but yearly turned out several papers. When he wrote a paper, he was besieged for reprints. Requests came in by the hundreds. One of his puzzled colleagues sought the reason. "Clarence," he said, "when I write a paper it is usually based on months and months of research, and what I report always has newness. I pour out my heart in all my manuscripts, and then after publication, I may get ten requests for reprints. You do no research and your papers usually only restate and review the fundamentals of occupational health. Then you get 800 requests for reprints and I get ten. What is

the reason for all this?" Clarence Selby gently stated to his friend, "You have not learned the great lesson.

When I write I merely restate a lot of old principles, better known to my readers than to me. Always these readers fully agree with what I stated, so they think my paper is remarkable and they think I am a remarkable writer. They begin to think they themselves could have written that paper. So, quickly one and all write me wanting reprints. The lesson you have not learned is that most persons resent newness and resent what they do not already fully understand. You write for the ages and record your newness, while I write for the immediate and all who fall in line. If you want a wide reading of your papers, write so that every reader thinks that he wrote the paper, or at least could have written it, and better." (Carey P. McCord: "Industrial Physicians in Fetching Stories." *Jl. Occupational Med.* (Aug.) 1973, pg. 656).



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Maybe you can count the people in your corporation on one jaw. But even if your business isn't big, you can still set up a money-making profit sharing plan. Our *Master Profit Sharing Plan* makes it easy.

Do you know why more and more incorporated professionals use profit sharing? First, it's a tax shelter for your income. You can put up to 15% of payroll in the plan. Second, professional money managers keep your money invested, so your profits produce more profits. Nobody can guarantee what rate of return you'll get. But here are the amounts you could

receive if you put aside just \$1,000 per year for 25 years:

Rate of Return (Compounded Annually)	Total in 25 years
8%	\$73,106
6%	54,865
4%	41,646

When you adopt our Master Profit Sharing Plan nearly two dozen of Chicago's best qualified money managers watch over your investments. They're backed up by thorough economic analysis, market research and eighty five years of profitable history in assets management. We handle all the details too. The paperwork, rec-

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Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R^{*}

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

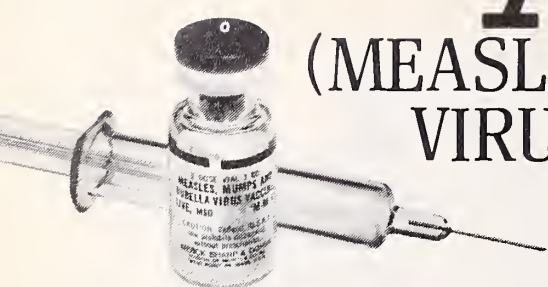
^{*}Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions. Encephalitis and other nervous system reactions that have

occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1-9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

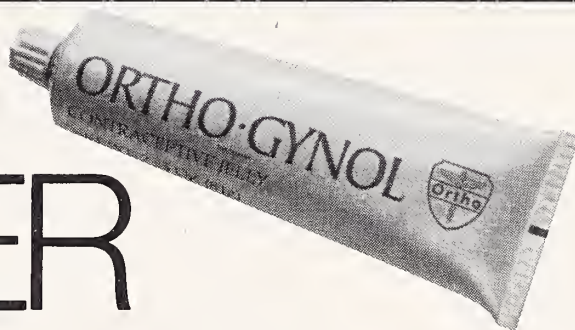
How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK
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A VERY SOUND BARRIER



For patients who can't or won't use the "pill" or an IUD

While no contraceptive is one hundred percent effective, the Ortho All-Flex Diaphragm and Ortho-Gynol Contraceptive Jelly, together, act as a very effective barrier to conception and is a method that is rarely contraindicated.

Ortho All-Flex is designed to provide comfort and reliability and to meet the highest esthetic standards of the most discriminating women.

Ortho All-Flex Diaphragms are made of high quality, long-lasting latex. They won't discolor when used with Ortho-Gynol Contraceptive Jelly or Ortho-Creme* since these contain no phenylmercuric acetates. No introducer is needed; the unique spring-within-a-spring construction forms a perfect arc wherever compressed.

Consider the advantages of prescribing the Ortho All-Flex Diaphragm and Ortho-Gynol when you and your patient decide on the diaphragm and jelly method of conception control.



If you would like a professional fitting-ring set and fitting-procedure brochure, please contact your Ortho representative.

Ortho Pharmaceutical Corporation, Raritan, New Jersey 08869

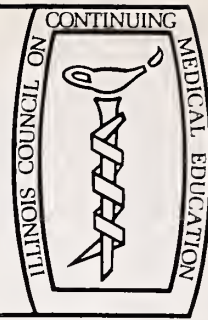
The Ortho All-Flex*
Diaphragm with
Ortho-Gynol*
Contraceptive Jelly

*Trademark

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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

JANUARY

Anesthesiology

CLINICAL ANESTHESIA PRACTICE

For: Anesthesiologists. 22-day postgraduate traineeship, Jan. 3-31, 1974, Chicago, Ill.

Hrs. of Instr.: 176. CME Credit: AMA Category 1. Fee: \$400.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Cardiology

ECHOCARDIOGRAPHY WORKSHOP

For: Cardiologists. 4-day symposium, Jan. 14-17, 1974, Indianapolis, Ind.

Hrs. of Instr.: 26. CME Credit: AAFP, AMA Category 1. Fee: \$125. Regis. Limit: 50.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

CARDIOLOGY TODAY—RECENT ADVANCES IN TREATMENT & DIAGNOSIS

For: All physicians. 4-day conference, Jan. 28-31, 1974, Iowa City, Iowa.

Hrs. of Instr.: 32. CME Credit: AMA Category 1. Fee: \$200. Regis. Limit: 12.

Sponsor, contact: Univ. of Iowa College of Med., Newton Rd., Iowa City, Iowa 52242.

WHAT TO DO IF YOUR PATIENT LIVES AFTER HEART SURGERY OR A HEART ATTACK

For: All physicians, R.N.s. Workshop, Jan. 31, 1974, University Center Auditorium, Southern Ill. Univ., Carbondale, Ill.

Hrs. of Instr.: 6. CME Credit: AAFP. Fee: \$10 (M.D.s); \$7.50 (R.N.s). Regis. Limit: 300.

Sponsor, contact: Professional Education Planning Committee, Service Area Y, Ill. Heart Assn., West Mill St., Carbondale, IL 62901.

Endocrinology

CLINICAL ENDOCRINOLOGY

For: Family Physicians, Pediatricians, Internists. Symposium, Jan. 16, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Gastroenterology

COLON DISEASE AND COLONOSCOPY

For: Family Physicians, Surgeons, Gastroenterologists, Radiologists, Pathologists. 1½-day symposium, Jan. 25-26, 1974, Pfister Hotel, Milwaukee, Wis.

Hrs. of Instr.: 10. CME Credit: AAFP. Regis. Limit: 150.

Sponsor, contact: Anne T. Finnegan, Office of Cont. Educ., Medical College of Wisconsin, 561 N. 15th St., Milwaukee, Wis. 53233.

FIBEROPTIC COLONOSCOPY

For: All physicians. 3-day course, Jan. 28-30, 1974, Chicago, Ill.

Hrs. of Instr.: 21. CME Credit: AMA Category 1. Fee: \$125. Regis. Limit: 10.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FEBRUARY

Family Medicine

MEDICINE FOR TODAY (Spring Series)

For: Family Physicians. Series of correlated lectures, Feb. 28-Mar. 28, 1974, at these cities: Belleville, Berwyn, Centralia, Champaign, Chicago (North, Near West, South West), Elgin, Hinsdale, Kankakee, Melrose Park, Park Ridge, Peoria, Rockford, Rock Island, Springfield.

Hrs. of Instr.: 12. CME Credit: AAFP. Fee: \$45 (members), \$50 (non-members). Regis. Deadline: Feb. 1, 1974.

Sponsor, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

Internal Medicine

FRED PRIEBE MEMORIAL SYMPOSIUM ON ARTHRITIS

For: Internists, Family Physicians. Symposium, Feb. 6, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

LIVER DISEASES

For: All physicians. Seminar, lecture, Feb. 15, 1974, 10 a.m., Forkosh Memorial Hospital; Feb. 15, 6 p.m., Lincolnwood Hyatt House; Feb. 16, 10 a.m., Bethany Methodist Hospital.

Hrs. of Instr.: 5. CME Credit: AAFP, AMA Category 1. Fee: \$15 (non-staff, lecture & dinner). Regis. Deadline: Feb. 9, 1974.

Sponsor: FAB-CME. Contact: Mr. S. Plotner, Forkosh Memorial Hospital, 2544 W. Montrose Ave., Chicago, IL 60618; (312) 267-2200.

Psychiatry & Neurology

COMBINED PSYCHIATRIC & NEUROLOGIC DISORDERS

For: Psychiatrists, Pediatricians, Neurologists, Family Physicians. Symposium, Feb. 13, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Your Ideas, Please

If there's a continuing education course or other learning service not now available that you'd find helpful—please write us about it, or jot a note on your prescription pad. Periodically, we'll tabulate those ideas and transmit the information to appropriate CME sources.

Regretfully, available staff does not permit responses to individual suggestions.

MARCH

Cancer

DIAGNOSIS & MANAGEMENT OF MAMMARY CANCER

For: All physicians. Frontiers of Medicine lecture, March 13, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instr.: 3. CME Credit: AAFP, AMA Category 1. Fee: \$15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

Individual Physician Profile

An unusual service for Family Physicians offered by the University of Wisconsin, IPP provides opportunity to (a) analyze your practice, (b) be tested on the medical problems you see most often, and (c) receive educational suggestions based on your and your patients' needs. Included also is a personal consultation (by telephone) as well as a computer print-out of CME courses and study materials directly related to your practice problems.

For full information, write to . . .
Individual Physician Profile
Dept. of Continuing Medical Education
The University of Wisconsin
610 Walnut Street
Madison, Wis. 53706

Internal Medicine

IMMUNOLOGY OF INFECTIONS

For: Pediatricians, Internists, Family Physicians. Symposium, March 6, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

INTERNAL MEDICINE REVIEW

For: Internists, Pediatricians, Family Physicians. Symposium, March 20-21, 1974, Atkinson Hotel, Indianapolis, Ind.

Hrs. of Instr.: 12. CME Credit: AAFP, AMA Category 1. Fee: \$50.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

JANUARY

Internal Medicine

ARTHRITIS

For: All physicians. Lecture, seminar. Jan. 11, 1974, 10 a.m., Bethesda Hospital; Jan 11, 6 p.m., Lincolnwood Hyatt House; Jan. 12, 10 a.m., Forkosh Memorial Hospital, Chicago, Ill.

Hrs. of Instr.: 5. CME Credit: AAFP, AMA Category 1. Fee: \$15 (non-staff, lecture & dinner). Regis. Deadline: Jan. 5.

Sponsor: FAB³-CME. Contact: Mr. Neil Glass, Bethesda Hospital, 2451 W. Howard St., Chicago, IL 60645; (312) 761-6000.

Obstetrics/Gynecology

SEX AND THE MEDICAL PRACTITIONER

For: All physicians. Frontiers of Medicine lecture. Jan. 9, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instr.: 3. CME Credit: AAFP, AMA Category 1. Fee: \$15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

GYNECOLOGICAL LAPAROSCOPY

For: All physicians. 5-day course, Jan. 14-18, 1974, Chicago, Ill.

Hrs. of Instr.: 15. CME Credit: AMA Category 1. Fee: \$200. Regis. Limit: 8.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

VAGINAL APPROACH TO PELVIC SURGERY

For: All physicians. 5-day course, Jan. 14-18, 1974, Chicago, Ill.

Hrs. of Instr.: 20. CME Credit: AMA Category 1. Fee: \$150. Regis. Limit: 16.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Pediatrics

CURRENT PEDIATRIC MANAGEMENT—A New & Individualized Teaching Course

For: All physicians. Symposium, Jan. 9, 1974, Indianapolis, Ind.

Hrs. of Instr.: 7. CME Credit: AAFP, AMA Category 1. Fee: \$35. Regis. Limit: 100.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Jan. 17, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. Contact: Raymond L. Del Fava, M.D., Secy., Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

KIDNEY TRANSPLANT

For: All physicians. Lecture, Jan. 23, 1974, Martha Washington Hospital, Chicago, Ill. Speaker: Fredrick K. Merkel, M.D., Presbyterian-St. Luke's Hospital.

Hrs. of Instr.: 1. CME Credit: AAFP, AMA Category 1. Sponsor, contact: Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618.

PRIMARY & METASTASTIC BRAIN TUMORS

For: Surgeons, Internists, Pediatricians, Family Physicians. Symposium, Jan. 30, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Trauma

HOSPITAL PROGRAM ON GENERAL SURGERY/TRAUMA

For: All physicians. Monthly clinical program, Jan. 15, 1974, 8 p.m., Passavant Pavilion, Northwestern Memorial Hospital, Chicago, Ill.

Hrs. of Instr.: 2. Fee: none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. Contact: Arne Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

FEBRUARY

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Feb. 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. Contact: Raymond L. Del Fava, M.D., Secretary, Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

MEDICAL EMERGENCIES

For: All physicians. Frontiers of Medicine lecture, Feb. 13, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instr.: 3½. CME Credit: AAFP, AMA Category 1. Fee: \$15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, Feb. 19, 1974, 8 p.m., Cook County Hospital, Chicago, Ill.

Hrs. of Instr.: 2. Fee: none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. Contact: Howard Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

EMERGENCY CARE

For: Family Physicians, Surgeons, Internists, Cardiologists. 1½-day seminar, Feb. 23-24, 1974, Pfister Hotel, Milwaukee, Wis.

Hrs. of Instr.: 10. CME Credit: AAFP.

Sponsor, contact: The Medical College of Wisconsin, 561 N. 15th St., Milwaukee, Wis. 53233.

Your Personal Learning Plan

Are you satisfied that your CME is producing full benefits for the time (and money) invested? If you've any doubts, try *Your Personal Learning Plan*, a 32-page pamphlet intended to help the individual physician plan CME in a systematic fashion.

While written chiefly for primary-care practitioners—family physicians, internists, pediatricians—the pamphlet can also be useful to those specialists who ordinarily deal with a smaller range of medical problems.

A unique feature of this handbook is a special set of worksheets—similar in format to the patient medical record—to help you think through and record YOUR personal learning plan.

Any Illinois physician (MD or DO) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to ICCME (address above). To all others, the cost is \$1.00/copy postpaid (90¢ each in quantities of 100 or more).

MARCH

Neurology/Ophthalmology

CLINICAL NEURO-OPHTHALMOLOGY

For: Neurologists & Ophthalmologists. Symposium. March 27, 1974, Methodist Hospital, Indianapolis, Ind. Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Otolaryngology

HEAD & NECK ANATOMY & CLINICAL OTOLARYNGOLOGY

For: Otolaryngologists. Symposium, March 18-29, 1974, Indianapolis, Ind.

Hrs. of Instr.: 112. CME Credit: AAFP, AMA Category 1. Fee: \$650. Regis. Limit: 27.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Pediatrics

CHRONIC ILLNESS IN CHILDHOOD

For: Pediatricians. Half-day roundtable, March 20, 1974, Loyola University Medical Center, Maywood, Ill.

Hrs. of Instr.: 4. Fee: \$10. Regis. Deadline: March 18, 1974.

Sponsor: Dept. of Pediatrics, Loyola Univ. Stritch Sch. of Med. Contact: Pediatrics Roundtables, c/o Eugene F. Diamond, M.D., 2160 S. 1st Ave., Maywood, IL 60153.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Lecture, March 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. Contact: Raymond L. Del Fava, M.D., Secretary, Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

Surgery

SURGERY REVIEW

For: Surgeons. Symposium, March 14-15, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. CME Credit: AAFP, AMA Category 1. Fee: \$35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Trauma

HOSPITAL PROGRAM ON GENERAL SURGERY/TRAUMA

For: All physicians. Monthly clinical program, March 12, 1974, 8 p.m., Loyola Univ. Medical Center, Maywood, Ill.

Hrs. of Instr.: 2. Fee: none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. Contact: Arne E. Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, March 19, 1974, 8 p.m., Illinois Masonic Hospital, Chicago, Ill.

Hrs. of Instr.: 2. Fee: none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. Contact: Howard W. Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

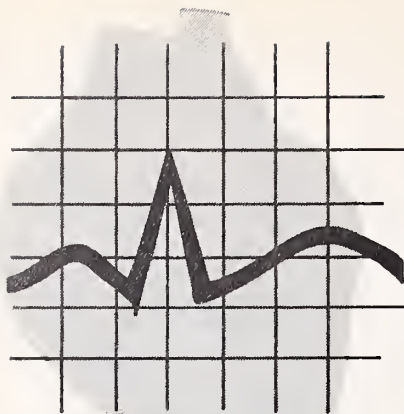
Recent CME Accreditations

The ISMS Committee on CME Accreditations has recently approved the CME programs of these institutions:

Martha Washington Hospital, Chicago

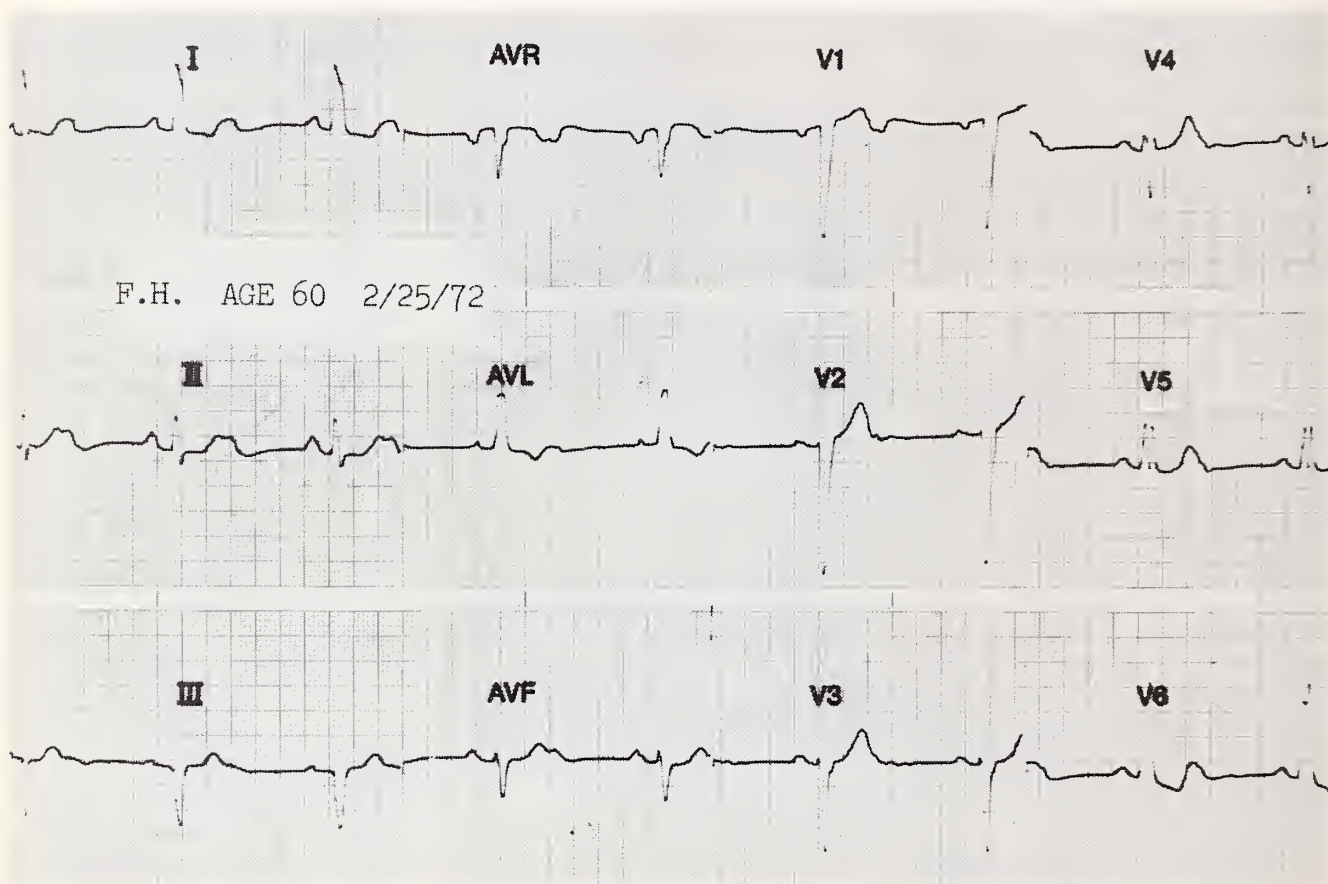
Oak Park Hospital, Oak Park

FAB³-CME (a consortium of 5 Chicago hospitals for CME purposes: Forkosh, American, Belmont Community, Bethany Methodist, & Bethesda)



ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine



A 60-year-old housewife was referred for evaluation of recurrent lightheadedness and several episodes of syncope at rest. No history of drug therapy. Physical examination was unremarkable except for a pulse of 40/minute.

Questions:

1. ECG taken on admission shows:

- A. RBBB, complete
- B. Complete A-V heart block
- C. LBBB, complete
- D. 2° A-V block (Mobitz Type II)
- E. Bilateral bundle branch disease

2. The following statements can be made about the clinical course:

- A. Recurrent syncope is likely
- B. Syncope is not related to heart disease
- C. Patient will benefit from pacemaker
- D. Complete A-V heart block may occur
- E. Condition is self limiting and requires no treatment

(Answer on page 604)

Editorials



How Not to Get Physicians

There is a shortage of physicians in many areas of Illinois. New medical schools have been opened but many of our graduates leave the state to practice elsewhere. (See the lead story in this issue.) A well-conceived program to encourage physicians to remain in Illinois is under way.

We are now confronted with groups who may or may not be familiar with the difficulties we are having with physician shortages and wooing more recent graduates to practice in Illinois. Some legislative bodies are reconsidering relicensure and others recertification of our specialists. The need for relicensure is highly debatable and somewhat insulting to most doctors. It is a highly discriminatory plan unless the legislature is willing to relicensure lawyers, dentists, osteopaths, nurses, veterinarians and all other professions. We should fight this proposal "tooth and nail" if it comes before the House. These unnecessary "roadblocks" will definitely put a damper on any program to encourage physicians to practice in Illinois.

Recertification at the state level will be very expensive and impractical. At present, certification is done by the various specialty boards at a

national level. There are more than 20 major specialty boards and another 30 subspecialty boards. Conflicts are unavoidable. What will happen if the American Board of Surgery certifies a surgeon and a newly-created "state Board of Surgery" decertifies him several years later? Perhaps one of his competitors is giving the examination and he is flunked just for spite. It could happen. All of this would discourage many young specialists from practicing in Illinois.

The expense of establishing state boards of some 22 major specialties along with the examiners and staff could cost millions. In addition, it sets up another bureaucracy. But, more important, it adds another barrier to those already established in the state. It definitely will not help any recruiting program for new physicians.

If our legislators or state boards want to protect our citizens from the doctors who practice poor medicine, they should suspend or revoke licenses for incompetence. One approach is through peer review. Another possibility is continuing education, even though there is no proof that it keeps a doctor on his toes.

T. R. Van Dellen, M.D.
Editor

Guest Editorial

The Peril of "Non-Peer Peer Review"

On July 22, 1973, before the Annual Meeting of the American Pharmaceutical Association, Sen. Edward Kennedy (D-Mass) called for "peer review" of physicians by pharmacists, and asked a number of rhetorical questions reflecting adversely upon practices of the pharmaceutical manufacturing industry.

As a physician, a member of organized medicine, and Chairman of the ISMS Board of Trustees, I cannot remain silent about my concern about Sen. Kennedy's proposal for prescription review.

Sen. Kennedy identifies the pharmacist as a professional, equating him with the physician. I do not deny that a pharmacist should be considered a professional; however, the role of the pharmacist in health care cannot be compared to or equated with that of the physician.

The physician is intensively prepared for 12 years or more before he makes independent medical decisions. How can anyone consider that the judgment of a pharmacist, usually with a four-year college degree, can override or question decisions made by a qualified physician? The

pharmacist has no history on the patient, is not knowledgeable regarding allergies and related illness, and has absolutely no knowledge of the rationale and differential diagnosis of the physician. In fact such review, by extension, could be considered the unlawful practice of medicine.

Sen. Kennedy proposed that the pharmacist would instruct the public on how to take prescribed medications, and also indicate if the drug is experimental. I am sure most physicians do this before issuing a prescription. The physician may or may not dispense medicine; if he does not, he then trusts that the pharmacist selected by his patient will carry out the written order or prescription.

Sen. Kennedy's proposal could encourage serious contrary action on the part of the pharmacist who may substitute one brand of drug, supposedly equal, for that which the physician has specified. Such substitution does not take into full account lack of generic and chemical equivalencies, bioavailability and absorption rates, allergies to carriers, and previous experience with the individual patient as well as expertise and acumen in treatment of many patients.

The pharmacist may defend this action as a means of offering a lower cost of medical care to the public. It never ceases to amaze me that the pharmacist, a professional, might want to betray the trust of a physician, or be of disservice to the public. The saving, if any, the pharmacist might pass on to his customer could, instead, provide the patient with medication which could cause an adverse drug reaction.

Obviously, the physician has reason for selecting a specific drug; the physician's main concern is the end result. A patient gains confidence in his physician; similarly, the physician trusts certain drug brands for his patients, since his previous experience in similar instances is that the drug has been proven effective.

Sen. Kennedy questions why there has to be more than one pharmaceutical house manufacturing the same products. The answer is simple . . . competition. The United States, unlike other countries, does not own or monopolize and dictate to the manufacturers; thus, competition usually tends to keep prices down. Is it not the spirit of free business competition which has made this country so desirable a place to live?

Sen. Kennedy misrepresents drug prices by selecting the most drastic differences; he compares the cost of the highest-priced brand of an

innovator company to the lowest prices of "generically" produced products. If the Senator would have consulted an objective experienced pharmacist, he would know that the listed catalog price of a trademark drug generally overstates the average transaction price; and the catalog price of a generic version tends to understate what the pharmacy actually has to pay.

Another unfair rhetorical question asked by the Senator was, "Why the excessive profits in the drug industry?" The drug industry is no different from any other business; return must exceed expenses. Every drug under development by a pharmaceutical company will not be profitable. Much time, research, and money must be put into the production of a new drug. If the product "flops," then the pharmaceutical company has to absorb this expense through sales of a product that is successful. What industry isn't faced with maintaining the same balance?

The Senator also pointed out the small amount of time spent by the physician studying pharmacology in medical school. Unfortunately, busy physicians often cannot devote enough time to keep up with all new drugs. I feel that organized medicine can assist the physician in this area through scientific publications and continuing medical education. I also am hopeful that state medical associations will encourage medical schools to offer more complete studies in pharmacology. This subject, as any other medical subject, changes constantly. So continuing medical education, publications which feature scientific articles, and first-rate pharmaceutical advertising will have to assist the physician in keeping abreast in this area, and in all other areas of medicine.

In conclusion, I strongly advocate that all physicians be alert to proposals such as these made by Sen. Kennedy. We must oppose any health care measure which would enable a pharmacist to perform peer review of medical care.

Physicians must convince the public that data which is distorted and taken out of context, as in Sen. Kennedy's presentation, do not fairly represent the drug industry or the physician. Physicians must rebut conflicting regulation or legislation which will misrepresent our professional training and stature, and which will interfere with delivery of the highest quality of care possible, tailored to the need of each individual patient. ◀

William M. Lees, M.D



membership forum

Dear Editor:

I congratulate you for your editorial stand in the September, 1973, issue of the *IMJ*, ("Selecting Medical Students"). You have lucidly described a basic deficiency in the attitudes of many medical school admission committees. Presently I am practicing medicine in rural Illinois only because of the Illinois State Medical Society-Illinois Agricultural Assoc. program. Except through the auspices of this program, I would neither have been accepted into the University of Illinois College of Medicine, nor would I have been able to enjoy the rewards of a rural community medical practice. My personal testimony may or may not be generally representative, but I feel it does add credence to your statement.

My father was a small dairy farmer in Illinois who was able to weather the depression, pay off his 178 acre farm, creditably raise eight children (sending four through college) and, at the same time, set an example of community service through serving in various public offices. Although I graduated at the head of my small high school class, I was relatively poorly prepared for the competition for grades that I encountered in college. I was strongly attracted to the sciences in college, but my greatest affection was directed towards the humanities. This combination of interests, motivation, and native intelligence brought me squarely to the door of medicine—but without the ISMS-IAA sponsorship, I quite clearly could not have entered through those portals (at least this is what the Dean of Admissions "indicated" to me at that time). Once into medical school, I excelled well enough to be invited into Alpha Omega Alpha honorary academic society at the end of my sophomore year, and I was respected well enough by my peers to become one of three in my class to be voted the Francis E. Senear clinical award. These awards were very personally satisfying, but they are not a close second to the rewards I have felt in my heart from working with the "homely" people in this rural Galena community. For certain, this would not have been the case if I had listened to the medical school admission committee or to my professors in that school. In regard to the latter, I can very vividly recall the stigma applied to anyone overtly expressing a desire to practice family medicine (this was in 1962-1966); the "L.M.D." label, by itself, should have been enough to convert many individuals to sheepish

believers. At the time, it was nearly incomprehensible to me how the taxpaying people of Illinois could allow themselves to continue to be exploited by funding a medical school whose basic attitude was such as to nearly guarantee the demise of quality rural medicine.

You are correct in pointing out that there are more noble goals in life and medicine than financial gain and social status. I would like to presume that this is what you are referring to when you describe "a place for less ambitious applicants with more altruistic attitudes" (it's the "less ambitious" terminology in your statement that bothers me). Certainly, academic attainments cannot necessarily be equated with intellectual ability, altruistic attitudes, "success" as a physician or any combination thereof. This brings us back full circle to the deficiencies of the traditional formal admission policies of medical schools, as you have pointedly delineated in your editorial.

Another article in the September *IMJ*, "Continuing Medical Education and Professional Growth—The Physician's Protection," by Thomas Meyer, aptly attacks another sacred cow. The rural community physician has received very little realistic support in his needs for continuing medical education and professional growth. Medical educators have, up to this point, seemed to be quite oblivious to these particular needs. I personally have traveled hundreds of miles, spending hundreds of dollars, with many hours taken away from my practice, to listen to "expert educators" lecture to me about subject material that I could have read in one of my journals—and in a small fraction of the time I wasted going to the "program." Needless to say, I have quit attending these travesties, much the same as I quit listening to many of my medical school professors who seemed to value pipettes over people and scientism over humanism. The philosophy that Dr. Meyer presents does, indeed, seem promising which can be seen through the efforts of the Illinois Council on Continuing Medical Education. This could go a long way towards countering the dulling prospects of professional stagnation that many physicians may realistically fear in a rural practice.

Again, I congratulate you for your searching concern about rural medicine.

Sincerely,
W. E. Johnson, M.D.

The Treatment of Accessible Malignant Tumors By Irridation

(Continued from page 563)

cobalt would develop its usual radioactivity; the titanium, becoming mildly radioactive, would lose its activity with a few weeks. The radioactive ball bearings are placed in a unit called a "Pneumatron," which consists of a lead reservoir one foot in diameter. The bearings rest in a tube, the distal end of which connects with an applicator. Different applicators are designed for the mouth, the skin, or the vagina. The applicator is fixed in the area to be treated. The operator, by means of compressed air, forces the titanium balls out of the lead reservoir and into the prefixed applicator from controls in another room.

I have used the Pneumatron for the past four years with success in both skin and intraoral tumors. These include six intraoral cancers—two Stage I, two Stage II, one Stage III and one Stage IV—all of which have completed their treatment with apparent destruction of their primary growths. Two other patients had infectious granulomas with extensive destruction of oral tissues and one patient had a rapidly growing angionoma of the tongue. These three patients received complete relief.

Five other patients with cancers of the mouth were treated. Two had far advanced disease and were unable to complete their courses of treatment; another had an involvement of the mandible and was referred for a hemi-mandibulectomy; and two others, with extensive disease treated previously elsewhere, were not relieved. One patient with numerous skin cancers was entirely relieved and one patient was given preoperative radiation for cancer of the breast. There are several more patients now under treatment most of which have cancers in the mouth.

It is my belief that radiotherapy of accessible tumors in the future will be performed with some such unit. In the treatment of recurrent cancer of the breast, it is possible to deliver almost any desired dose to the full thickness of the chest wall without danger to the underlying lungs.

The cost of the unit will be a fraction of the cost of the commonly used cobalt bomb unit. In addition, patients are ambulatory and there is no need for expensive hospitalization. ◀

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Allergic Aspergillosis in a Family

(Continued from page 566)

mined, she probably had granulomatous lesion such as tuberculosis secondary to the aspergillosis, or the reverse may be true. The nodular lesion probably represented tuberculosis since second strength PPD was positive at 14 months of follow-up although repeated cultures of sputum, and bronchial secretions were negative for pathogenic acidfast-bacilli. Or this may be similar to a case reported by Edge et al (*Chest* 59: 407, 1970) in which the patient with assumed tuberculous lung lesions developed typical mycetoma at two years. Lobectomy would be necessary even for a diagnostic test in this mother. Her bilateral lesions also minimized the surgical indications; however, she is doing quite well on current therapy. Also, because she had an adverse anesthetic reaction, we do not want to risk surgery. Corticosteroids were not used in this case because tuberculosis could not be ruled out. The known toxicity and difficulties of administration of Amphotericin B contraindicated its use when the clinical course was stabilized.

Summary

In summary: three patients in one atopic family developed pulmonary aspergillosis within one month. The diagnosis was confirmed by positive sputum and potting soil cultures for *Aspergillus fumigatus* and all three sera were positive for precipitating antibodies against the *Aspergillus* antigen. The mother had persistent nodular infiltrates in the right upper lobe which probably represented aspergillus granuloma or tuberculosis.

Non-tuberculous pulmonary lesions in atopic patients may represent allergic aspergillosis. The crucial diagnostic test is the positive immediate and late (4-5 hours) intradermal reaction to *Aspergillus fumigatus*. ◀

Headache Associated with Low Spinal Fluid Pressure Syndrome

(Continued from page 591)

symptoms, lumbar puncture reveals a low CSF pressure.²

Low spinal fluid pressure is often accompanied by mild pleocytosis of CSF (particularly RBC presumed to be the result of diapedesis of red cells) and moderate elevation of protein.^{3,5}

Symptoms of primary intracranial hypotension usually subside spontaneously in varying lengths of time from 2 to 16 weeks and no treatment may be necessary.³ As for the treatment, aside from general measures (bedrest, antipyretics) many specific therapeutic measures have been recommended by different authors including intravenous injections of hypotonic saline solutions, cerebral vasodilators (papaverine, CO₂ inhalation). Pituitrin has been recommended for post-lumbo puncture intracranial hypotension. The intrathecal injection of saline, or Ringer's solution, seems to be most physiological of the above treatments as well as producing no adverse effects. Of course, care must be taken not to cause an iatrogenic meningitis. In cases that have prolonged

symptoms, the authors feel that the intrathecal injection of saline or Ringer's solution is the treatment of choice.

Summary

Headache may be associated with a low spinal fluid pressure syndrome. It is severe, dull, usually bifrontal, but may encompass the whole head. It is aggravated in the upright position, sitting or standing, and relieved by lying down. Clinical signs are: spinal fluid pressure less than 70 mm. cerebrospinal fluid, bradycardia, increased spinal fluid red blood cells and protein. An important related phenomenon has been the presence of subdural hematomas. Method of choice is the addition of sterile saline intrathecally which results in complete relief of the headache. ◀

Bibliography

A complete bibliography for "Headache Associated with Low Spinal Fluid Pressure Syndrome" may be obtained by writing to: Illinois Medical Journal, 360 N. Michigan Ave., Chicago, 60601.

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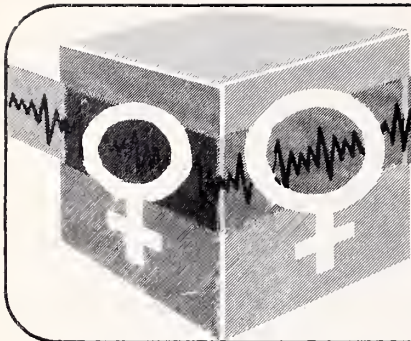
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pulse... of the doctor's wife

MRS. ROSANNE K. FRANK, *Editor*

ISMS-WA Health Education Symposium Announcement Letter

Dear Members of the Woman's Auxiliary:

The first Health Education Symposium sponsored by the Illinois State Medical Society and the Woman's Auxiliary will be held February 28, 1974 at the LaSalle Hotel, Chicago.

Through studies and programs in health education it is becoming increasingly obvious that there is much duplication and fragmentation of community efforts. In addition to the need for improved school programs and teacher training it is necessary to develop coordinated community programs directed towards **the improvement of health for all citizens**. The Health Education Symposium approved by both ISMS and Auxiliary will bring together the leadership of many Illinois organizations to discuss cooperative action to establish broad-based programs of health education rather than current crisis-oriented efforts.

The Symposium program is planned to include the thinking and direction of other Illinois organizations whose activities and interests are related to health care. The purpose of the Symposium will be:

1. **To improve** the quality of life.
2. **To motivate** people to help themselves.
3. **To develop** local programs responsive to the needs of the people.
4. **To increase** the level of awareness of the need to change priorities.
5. **To encourage** people to assist in the development, expansion and extension of Health Education on all levels of community.
6. **To promote health education** in the schools of Illinois through the implementation of the "Critical Health Problems and Comprehensive Health Education Act" that was passed by the 77th Illinois General Assembly and signed into law on August 31, 1971.

The Woman's Auxiliary will have leaders from counties taking an active part in the Symposium. Charged with a state-wide emphasis of instituting a broad program of health education throughout Illinois, **each county auxiliary will be requested to act as a catalyst in organizing similar county education meetings** and local round-table discussions to consider the needs of their communities and determine a course of action using available local resources.

With your cooperation and participation in the Health Education Symposium we will be taking a positive step in promoting a state-wide awareness of the need to establish effective Health Education Programs. Please mark your calendar . . . February 28, 1974.

Woman's Auxiliary, Health Education Symposium Committee
Mrs. Wendell Roller, *Co-Chairman*
Mrs. John Ovitz, Jr., *Co-Chairman*
Mrs. Robert Hartman, *President*

Councilors of the Month

Each Month we shall try to feature your COUNCILORS—picture and story, if possible. If you have one in your district that you are particularly proud of, and who is too modest to tell us her story, just prod her—and get over there with a camera and snap a good photo, and tell us ABOUT HER!



Suzanne Webb

Mrs. Robert (Suzanne) Webb

We know that Mrs. Robert (Suzanne) Webb, Edwardsville, Councilor for District 6, has been busy visiting ALL of her counties this fall, and we hope that her smile is broader than ever just thinking about all the good work being done by the auxiliaries down her way.

A little about **Mrs. Stanley (Barbara) Burris**, Springfield, Councilor for District 5. . . .

"I was born in St. Louis, Missouri, and still appreciate the changing seasons in that state and my adopted State of Illinois.

My husband was in medical school when we were married and I strongly supported the WA/SAMA. I have two lovely daughters and an 89 pound "would be" football player son. Our family are avid "circus buffs" and sailing novices. I'm a "just and fun" bridge player and will read anything—everything except directions!

I keep quite busy with activities and I am Immediate Past President of the high school PTA, Board Member of the Land of Lincoln Girl Scout Council, Sunday School teacher, Board of Christian Education member and participate in the Woman's Auxiliary to the Illinois State Medical Society.

I attended my first medical auxiliary meeting 15 years ago, and to my knowledge, I have only missed two meetings since that time. At the first meeting I paid my dues, signed up for a dance to be held the following month, and agreed to bake cookies for a bake sale. Still somewhat in a daze, I have managed to serve the county auxiliary in every office, except corresponding secretary, through the years with enthusiasm and I hope, good humor."

Members Attend Regional Workshop

Illinois was represented by six Auxiliaries at the North Central Regional Workshop in Cincinnati, Ohio, October 17-19. President and President-Elect, Bea and Mickey, were proud of the team: Barbara Burris, Membership; Jane Klaren, AMA-ERF; Lois Raber, Legislation; and Elizabeth Davis, Mental Health. The outstanding feature of Workshop is that it is a series of real working sessions where each chairman is privileged to be grouped with eleven women that are concerned with the same problems.

The Regional Presidents were guided to contribute and absorb aspects of their work such as budget, convention planning, membership, nominating committee, advisory committee, and newsletter, by Ruth Scrivner, WA/AMA President, who shared her knowledge and know-how most unsparingly.

News Briefs

Fall Leadership Conference of the WA/AMA was held in Chicago during October and your President Bea Hartman, and Acting President-Elect Mickey Glatter attended. Problems of *volunteerism* and *communication* in today's society were topics of discussion. Communication was defined as a two way street. WINNEBAGO COUNTY, under the leadership of Pat Hagman, has been doing it, apparently, as they have formed special interest groups—including gourmet cooking and dancing lessons. That's AFTER they get their AUXILIARY WORK done, no doubt, because they know that joining together in work and play puts them in a position where there is literally "nothing that cannot be accomplished".

* * *

Mrs. Thomas Glatter, Acting President-Elect, recently was featured in the *Northern Illinois Medical Journal*. Mrs. Glatter was quoted as stating that in the past five years through her visits in the state, she has noticed the trend for the counties in UNITY—both within the medical society and its' auxiliary. She notes the need for both the young and the old members—"the enthusiasm and the new ideas of the young are needed and the experience and wisdom of the more mature are essential." Mrs. Glatter feels that the problems facing the medicine today are bringing the members together to offer an acceptable solution.

Foreign Trained Physicians in Illinois

(Continued from page 559)

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Radiation Enteritis

(Continued from page 569)

Dr. Thomas Shields: In the treatment of carcinoma of the corpus, do you give preoperative radiation?

Dr. William Moss: The indications for preoperative radiation of carcinoma of the corpus are involvement of the cervix, an enlarged corpus or a poorly differentiated cancer. Anytime any one of these three things exist, preoperative radiotherapy is indicated in the management of carcinoma of the corpus of the uterus.

Dr. Thomas Shields: In this patient, why was X-ray therapy given?

Dr. Joseph Sherrick: The tumor did extend rather deeply into the myometrium. We thought there was a possibility that it had invaded into blood vessels and possibly this was the indication for radiotherapy. ◀

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View Box

(Continued from page 579)

Diagnosis—"Bezoars occurring in a gastric remnant after a gastrectomy." Classically bezoars are divided into three main types; trichobezoars, phytobezoars, and concretions. Phytobezoars, which consist largely of carbohydrate material bound together by proteinaceous matrix, may be due to poor mixing after antral resection, gastric stasis secondary to vagotomy and obstruction, and a reduction in acid pepsin secretion allowing accumulation of the proteinaceous matrix. Bezoars occurring after gastrectomy frequently present with intestinal obstruction due to passage of the bezoar into the small bowel.

In our case the scout film examination reveals a mottled mass which is located in the left upper quadrant and has a convex lower margin which would suggest a mass. The history of previous gastric surgery would account for its shape, as it probably represents a partial gastrectomy. The lateral decubitus film demonstrates a peculiar mottled density in the left upper quadrant. The appearance of a mottled density is highly suggestive of gastric contents. Note also the small metallic clips from the previous vagotomy which is a further hint of gastric surgery. The presence of the bezoar is confirmed by an upper GI. (Figure 3). It may simulate a carcinoma, however, the contents can be moved around by manual palpation during fluoroscopic examinations. The bezoar was fragmented under direct visualization during a gastroscopic procedure and the patient made an uneventful recovery. ◀

EKG of the Month

(Continued from page 596)

Answers: 1. C,D,E 2. A,C,D

The ECG shows prolonged PR interval, 2° A-V block with 2:1 conduction, and complete LBBB. This combination is suggestive of bilateral bundle branch block. Complete A-V block frequently follows. Syncope is common. Treatment of choice is a permanent pacemaker. ◀

Measles In Suburban Cook County

(Continued from page 000)

rate of vaccine failure. Over 60% of cases had had no vaccine at all, the rest had a currently unacceptable regimen.

Most cases (over 70%) were reported by schools. Less than 15% were reported by physicians.

Measles accounted for one death and about 12 hospitalizations during the outbreak.

Attempts at upgrading immunization levels will be made using information gathered during the outbreak. ◀

Acknowledgment

The cooperation of Dr. John B. Hall, M.D., M.P.H., Director, Cook County Department of Public Health, of private physicians and of school nurses is gratefully acknowledged.

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Abstracts of the Board of Trustees

(Continued from page 553)

Drs. Nathaniel Apter, Chicago; Paul Biedenharn, New Baden; John Bowden, Joliet; Edward W. Cannady, Belleville; Marshall Falk, Chicago; Julius Kowalski, Princeton; and Bertram Moss, Gerald Sobel and Jack Weinberg, all of Chicago.

In a related action, the Board agreed to re-activate a Committee on Aging under the Council on Social and Medical Services.

Illinois Professional Standards Review Organization (IPSRO)

The Board will request the ISMS Educational and Scientific Foundation to loan \$25,000 to the Illinois Professional Standards Review Organization from its fund allocated for unmet medical needs. The loan will be used for an educational program on IPSRO.

Director of Registration and Education Report

Dean Barringer, Director of the Illinois Department of Registration and Education, described departmental investigative procedures involving "sick doctors," stating that in order to revoke a physician's license IDRE must prove that the doctor is totally incapacitated because of alcoholism, drug addiction, etc. He also stated that his department has ruled that acupuncture is a surgical procedure, but he called for explicit language in the statutes, which now do not cover acupuncture at all. He urged the medical society or individuals to communicate directly with the department regarding instances of cultists involved in the practice of medicine.

Amendments to Bylaws

The Board approved the following proposed amendments to ISMS bylaws:

1. To qualify for ISMS membership, in-training members must be members of a component society, but need not be recommended by two members of the hospital staff where the candidate is in training.

2. Student members need not be members of the Student American Medical Association to qualify for ISMS membership.

3. Component societies must forward members' dues to ISMS by March 31 rather than May 1.

4. Academic physicians shall no longer be granted a 50% dues reduction.

These amendments will be presented to the 1974 House of Delegates for action.

A proposal to grant emeritus status to physicians at age 65 with 30 years membership was referred back to the Committee on Constitution and Bylaws for actuarial studies to determine the effect the change would have on the society's dues income. Further study also will be given a proposal to collect dues from full-time AMA employees who are members of ISMS. These physicians are presently classified as Service Members along with those in the armed forces. A plan to restructure ISMS district organizations by re-writing an entire chapter of the bylaws was likewise referred back to the committee for further study.

Publications

Provided there is no jeopardy of increased tax liability, the Board authorized an increase in the ISMS subscription rate to \$8.00 for the United States, Mexico, Cuba, Puerto Rico and the Philippine Islands; to \$10.00 for foreign countries in the Universal Postal Union and to \$8.50 for Canada.

A contract for the 1974 printing of the Journal was awarded to Neely Printing Co., Chicago, and a 5% increase in black and white advertising space rates was approved by the Board. The Journal was requested to make space available for intern-resident news briefs in accordance with a recommendation of the Council on Education and Manpower.

Revocation of County Society Charters

The Executive Committee will study the problem of inactive county medical societies and those which elect non-ISMS members as officers. Revocation of charters and other alternatives will be considered.

Uterine Cytologic Examination Law

The Maternal Welfare Committee will be asked to prepare a position paper on uterine cytologic examinations to be used as a basis for a legislative effort to repeal the existing act. In the meantime, legal counsel was authorized to give an opinion as to whether a hospital can legally order a medical procedure.

Opposition to Contingency Legal Fees

A plan to have the ISMS House of Delegates order legislative action to outlaw contingency legal fees will be given further study before resolutions are prepared.

Current Procedural Terminology

ISMS will encourage all providers and third-party carriers to adopt the third edition of Current Procedural Terminology as the standard, universal reporting mechanism for medical services in Illinois.

Mental Health Treatment of Minors

A proposal to amend the Mental Health Code to allow minors to receive psychiatric treatment without consent of parents was referred back to the Council on Mental Health and Addiction for further study after Board members objected to equating mental illness with venereal disease, which can be treated in minors without parental consent.

Health Insurance

The Governmental Affairs Council will study a proposal to have mental health treatment a benefit of all hospitalization policies written in Illinois unless the policy-holder specifically requests that this coverage not be included. The Board will decide on a future course of action following a report from this council.

In a related action, the Board referred to the Governmental Affairs Council a proposal to seek legislation that would require the inclusion of newborns in all hospitalization coverage by insurance companies.

Psychologists

The Board will request legal counsel to explore the constitutionality of a new Illinois law which allows "licensed clinical psychologists" to be reimbursed by third party payors and to recommend whether or not the law should be challenged. The Board also approved the draft of a bill defining medical psychotherapy and directed the Governmental Affairs Council to seek appropriate legislation.

Cigarette Sales in Hospitals

ISMS will seek the cooperation of the Illinois Hospital Association in eliminating the sale of cigarettes in hospitals and encouraging the use of special smoking areas for hospital visitors.

Assistant Surgeon Services

On the recommendation of the Council on Economics and Peer Review, the Board endorsed a position that a surgeon may arrange for competent surgical assistance whenever necessary. The assistant surgeon, if he is a referring physician, should submit his charge separately for the services he renders. If he is not the referring physician, however, the surgeon may pay the assistant directly and so indicate on his bill to the patient or third party.

Paying UR Committee Members

The Board will introduce a resolution in the next House of Delegates seeking approval for the principle of payment acceptable to physicians serving on all utilization review committees. In 1967 ISMS delegates objected to such payment.

Medicare Regulations Encouraging Fee-Splitting

The Board's attention was called to a Medicare regulation requiring a single billing for an injectable drug and the administration of the drug even though the drug is supplied by one physician and administered by another. Since the supplying physician must bill the physician administering the drug so that its cost is included in a single bill, the Board said this could be interpreted as a form of fee-splitting and it will seek to have the regulations changed by submitting an appropriate resolution to the AMA.

Aetna Insurance Letters

ISMS will protest the continuing practice of Aetna Life and Casualty Co. in requesting patients to notify the insurance company of physicians who charge over the "prevailing fee." The matter also will be brought to the attention of the Illinois Department of Insurance.

Ambulance Strategy Plan

The Board withheld endorsement of the ambulance strategy plan of the Illinois Department of Emergency Medical Services contingent upon evidence of physician participation at all local levels. The Board agreed that ISMS should prepare an informational slide presentation for county medical societies, but that it should be designed to encourage physician participation in local strategy committees rather than merely showing doctors what has been planned for them by a state agency. The Council on Social and Medical Services was directed to prepare a new slide presentation for the approval of the Executive Committee.

Health Care of the Poor and Migrant Workers

The Board authorized the Council on Social and Medical Services to develop a pilot conference on nutrition education for the Chicago area out-reach workers affiliated with accredited social and health organizations. If successful, the conference will be used as a model for a similar program downstate.

It also authorized a feasibility study of a proposed system which would improve health care to migrant workers and, with their help, establish a uniform health record on each worker. The health record would be available to physicians in all areas where the migrant may travel. The Council on Social and Medical Services was requested to report back to the Board on this matter.

The Board reviewed two resolutions which the Council on Social and Medical Services prepared for the House of Delegates. A proposal for ISMS to cooperate with the Illinois Department of Public Health in an on-going nutritional sur-

vey in low income areas to be conducted by residents of the area being investigated, was approved by the Board. A plan to seek legislation that would establish nutrition centers in Illinois schools was referred back to the Council on Social and Medical Services for reconsideration.

Hospital Satellites

The Board adopted a position statement that ISMS members should not be involved in hospital satellites unless there is a demonstrable need for such a facility in the community and the facility would provide accessible economic, efficient and effective medical care, placing good patient care above all other factors.

Medical Data on Drivers' Licenses

The Board approved, in principle, placing medical information on Illinois drivers' licenses and requested that an appropriate ISMS committee determine what medical information would be useful on the license. The committee's recommendations will be submitted to the House of Delegates in April.

Medical Disciplinary Board

The Governmental Affairs Council was authorized to seek legislation for a workable medical disciplinary system in Illinois. It was pointed out that the system will not work until the Medical Examining Board is provided with legal powers and mandate to act through adequate budget and staff.

Other Legislation

HB 637—Hazardous warning label on alcoholic beverages—to be supported if the bill is re-introduced.

HB 122—Physician certification of eyeglasses; support Governor's veto.

HB 251—Requiring IDPA to pay interest after 90 days; no action.

HB 724—Separating mental retardation from mental illness; no action taken on governor's veto, but Governmental Affairs Council was instructed to remain as involved as it deems appropriate.

HB 1427—Requiring health care providers to comply only with statutory mandates and not administrative regulations; support Governor's veto.

SB 447—Establishing fee-for-service system for Cook County staff physicians; ISMS to support whatever position the Governing Commission assumes regarding Governor's veto.

SB 501—Integrating Illinois born foreign medical students and graduates into health education and delivery system through a fifth pathway; implementation of fifth pathway supported.

Occupational Safety and Health

A recommendation from the Council on Education and Manpower that \$600 be granted the Chicago Area Committee on Occupational Safety and Health was referred back to the council. The grant would provide educational materials for medical students involved with industrial medicine.

Physical Therapy

The Board authorized the Medical Legal Council to explore allegations that physical therapy is being prescribed and practiced by unauthorized persons and to alert physicians of this situation if it is found to be true.

Confidentiality

The Board approved the following reaffirming statement on confidentiality:

"Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics, states: 'A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community.' The Illinois State Medical Society reaffirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good."

Acupuncture

The Board agreed to support legislation allowing physicians and dentists to use acupuncture for therapeutic or anesthetic purposes. Previously, the Board favored limiting its use to research. The Board also will oppose any activity to license acupuncturists and authorized the Medical Legal Council to make appropriate inquiry and investigation with the Department of Registration and Education to determine if the National College of Chiropractic in Lombard is utilizing acupuncture contrary to current rulings of R & E which indicate that acupuncture is a surgical procedure.

Clinical Conference and ISMS Annual Meeting

For purposes of financing, the Chicago Medical Society Clinical Conference and ISMS annual meeting will be considered simultaneous meetings. The Board approved a recommendation of the Joint Management Committee, which is composed of members of both sponsoring organizations, that ISMS would be responsible for expenses of the House of Delegates and related meetings and CMS responsible for the clinical conference and seminars, with promotion and publicity costs allocated to the party promulgating that portion. ◀

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Index to Volume 143

July through December, 1973

Page 1-88	July	265-440	October
89-168	August	441-530	November
169-264	September	531-618	December

A

Abstracts of Board of Trustees Meeting, 16, 198, 552
 Accidental Injection, (**PEDIATRIC PERPLEXITIES**), Ruth Andrea Seeler, 34
 Allergic Aspergillosis in a Family, (Vithayasai, Hyde & Floro) 564
 AMA Delegation (**REFERENCE ISSUE**) 326
 An Unusual Presacral Tumor, (F. Weiss, C. F. Vallejes and E. Tobias) 473
 Ancillary Organizations (**REFERENCE ISSUE**) 361
 Are You Satisfied With Your CME? (**SPECIAL ARTICLE**) Leonard S. Stein, Ph.D., 499
 Armbruster, Kent, *jt. author*, Case Report: Pancreatic Transplantation for Diabetes Mellitus (F. Merkel, W. G. Ryan, and T. S. Ing) 477
 Arrata, W. S. Michael, *jt. author*, Delayed Ovulation (M. Wingate, and L. Iffy) 44
 Asselmeier, Glen H., *jt. author*, Surgery and Anticoagulation Therapy (R. A. Dieter and R. M. McCray) 205

B

Baltes, Bernard J., *jt. author*, Headache Associated with Low Spinal Fluid Pressure Syndrome 560
 Beal, John, Editor, see (**SURGICAL GRAND ROUNDS**) 41, 131, 227, 418, 484, 520
 Best, George, *jt. author*, Celiac Artery Aneurysm (R. DeBord and R. Wright) 208
 Bihss, Francis E., Radiologist Honored 417
 Billings, Arthur A., *jt. author*, Febrile Reaction of Gaucher's Disease, (M. Post and C. M. Shapiro) 222
 Board Committees, (**REFERENCE ISSUE**) 346
 Board of Trustee Meeting, Abstracts of, 16, 198
 Boyd, David R., *jt. author*, Editor; (**TRAUMA CENTER**) Illinois Emergency Medical Service System Status Report II 210
 Breast Cancer—A Review of Cancer Registry from Blessing Hospital Quincy, Detection of, E. Greip 480
 Breed, J. Ernest, The Treatment of Accessible Malignancy Tumors by Irradiation 562
 Bronchogenic Cysts, (**SURGICAL GRAND ROUNDS**) 484
 Buell, Walter F., *jt. author*, Studies of Histoplasmosis in Two Illinois Communities 30

C

Celiac Artery Aneurysm, (R. DeBord, G. Best, and R. Wright) 208
CLINICS for Crippled Children 22, 104, 290, 514, 573
 Confusing Urinary Bladder Defects and Configurations C. Ney and H. L. Miller) 120
 Constitution and Bylaws (**REFERENCE ISSUE**) 305
 Cooper Quiz 150
 Councils of ISMS (**REFERENCE ISSUE**) 336

Cox, William, *jt. author*, (**TRAUMA CENTER**) Traumatic Rupture of Thoracic Aorta, (E. Sharp and R. Mullin) 56
 Crippled Children, Clinics for, 22, 104, 290, 514, 573

D

DeBord, Robert, *jt. author*, Celiac Artery Aneurysm, (G. Best, and R. Wright) 208
 DeHaen, Paul, **NEW PHARMACEUTICAL SPECIALTIES** 48, 146, 230, 428, 527, 580
 Delayed Ovulation, Martin Wingate, W. S., Michael Arrata and Leslie Iffy, 44
 Diagnostic Patterns in Disability in Illinois and the Nation, Harry E. Grant 587
 Diamond, Seymour, *jt. author*, Headache Associated with Low Spinal Fluid Pressure Syndrome. (Baltes) 560
 Dieter, Raymond A., *jt. author*, Surgery and Anticoagulation Therapy (G. H. Asselmeier and R. M. McCray) 205
 Diffenbaugh, Willis G., *jt. author*, (**SPECIAL ARTICLE**) Herman von Helmholtz 1821-1894, Physician, Musician and Versatile Scientist, (E. Strohl and R. W. Jamieson) 240
 Disability Insurance Under Social Security, Harry E. Grant 76
 Doctor, What Do You Know About Venereal Disease? 139
DOCTOR'S LIBRARY 60, 151, 425
DOCTOR'S NEWS 52, 143, 233, 415
 Drug Treatment of Hyperactivity in Children (P. S. B. Sarma and M. Faulk) 117
 Dunea, George, (**TRAUMA CENTER**) A Statewide System for Post-Traumatic Renal Failure 137

E

EDITORIALS

Why Go To Medical School (T. R. Van Dellen) 55
 The Goose That Laid the Golden Egg, Guest Editorial (W. David Steed) 55
 License Renewal (T. R. Van Dellen) 148
 Mini Editorial (T. R. Van Dellen) 148
 Selecting Medical Students (T. R. Van Dellen) 238
 Malpractice in the 14th Century (T. R. Van Dellen) 413
 Opportunistic Infection (T. R. Van Dellen) 513
 How Not to Get Physicians (T. R. Van Dellen) 597
 The Peril of "Non-Peer Review" (William M. Lees) 587
EKG OF THE MONTH, (Tobin, Nemickas, Scanlon, Moran, Talano, Johnson and Gunnar) 62, 136, 248, 414, 596

F

Falk, Marshall, *jt. author*, Drug Treatment of Hyperactivity in Children, (P. S. B. Sarma) 117
 Febrile Reaction of Gaucher's Disease, (A. Billings, M. Post and C. M. Shapiro) 222

Firor, Hugh V., **(PEDIATRIC PERPLEXITIES)** Repeated Bouts of Pneumonitis Cough With Feeding and Abdominal Distention 134
 Floro, Lourdes, *jt. author*, Allergic Aspergillosis in a Family (Vicharn Vithayasai and John S. Hyde) 564
 Foreign Trained Physicians in Illinois, Kong Meng Tan 555
 Frank, Rosanne, Editor, **(PULSE OF THE DOCTOR'S WIFE)** 69, 152, 246, 426

G

Gas Infection of Thigh **(SURGICAL GRAND ROUNDS)** John B. Beal, Editor 131
 Gastric Leiomyoma **(SURGICAL GRAND ROUNDS)** John Beal, 418
 Grant, Harry E., Disability Insurance Under Social Security 76
 Grant, Harry E., Diagnostic Patterns in Disability in Illinois and the Nation 587
 Greenwood, Ronald D., *jt. author*, Nonketotic Hyperglycemic Coma In Infancy (H. Traisman, M. Steiner and S. Hadawi) 37
 Griep, Ernest, Detection of Breast Cancer Registry from Blessing Hospital, Quincy 480
 Gunshot Wound of the Back **(SURGICAL GRAND ROUNDS)** John Beal, Editor 227

H

Hadawi, Sirus A., *jt. author*, Nonketotic Hyperglycemic Coma In Infancy (R. Greenwood, H. Traisman and M. Steiner) 37
 Headache Associated with Low Spinal Fluid Pressure Syndrome (Seymour Diamond and Bernard Baltes) 560
 Heart Attack, The Way to a Man's, Richard J. Jones 123
 Herman von Helmholtz, 1821-1894, Physician, Musician and Versatile Scientist **(SPECIAL ARTICLE)** (E. L. Strohl, W. G. Diffenbaugh, and R. W. Jamieson) 240
 Hletko, Paul J., *jt. author*, **(PEDIATRIC PERPLEXITIES)** Visceral Larva Migrans (Chandu Patel and Ruth Andrea Seeler) 574
 Hyde, John S., *jt. author*, Allergic Aspergillosis in a Family, (Vithayasai and Floro) 564
 Hyperactivity in Children, Drug Treatment of (P. S. B. Serma and M. Falk) 117

I

Idiopathic Pulmonary Hemosiderosis Anemia and "Pneumonia" **(PEDIATRIC PERPLEXITIES)** (Ruth A. Seeler) 421
 Iffy, Leslie, *jt. author*, Delayed Ovulation (M. Wingate and W. S. M. Arrata) 44
 Illinois Emergency Medical Service System Status Report II **(TRAUMA CENTER)** (D. R. Boyd and W. A. Pizzano) 210
 Illinois Society, American Association of Medical Assistants, 71, 149, 250
 Illinois State Government **(REFERENCE ISSUE)** 372
 Ing, Todd S., *jt. author*, Case Report Pancreatic Transplantation for Diabetes Mellitus (F. Merkel, W. G. Ryan, K. Armbruster and S. K. Seim) 477
 ISMS Services, **(REFERENCE ISSUE)** 351

J

Jamieson, Robert W., *jt. author*, **(SPECIAL ARTICLE)** Herman von Hemholtz 1821-1894, Physician, Musician and Versatile Scientist (E. L. Strohl and W. Diffenbaugh) 240
 Jannings, Charles J., III, **(SPECIAL ARTICLE)** "Where Have All the Doctors Gone?" 493
 Jones, Richard J., "The Way to a Man's Heart Attack." 123

K

Kravitz, Harvey, **(MEDICAL PROGRESS)** Prevention of Accidental Falls in Infancy by Counseling Mothers 570

L

Lees, William M., The Peril of "Non-Peer Review" **(EDITORIAL)** 597
 Legislative Report **(SPECIAL ARTICLE)** 107
 License Renewal **(EDITORIAL)** T. R. Van Dellen 148
 Love, Leon, **(VIEWBOX)** 36, 128, 244, 579

M

Malpractice in the 14th Century **(EDITORIAL)** T. R. Van Dellen 413
 Martin, Russell J., *jt. author*, Studies of Histoplasmosis in Two Illinois Communities 30
 McCray, Robert M., *jt. author*, Surgery and Anticoagulation Therapy (R. A. Dieter and G. H. Asselmeier)
 Measles in Suburban Cook County (Colette Rasmussen and James Mulrooney) 576
 Medical and Paramedical Education **(REFERENCE ISSUE)** 365
 Medical Assistants, Illinois Society, American Association of, 71, 149, 250
 Medical Legal **(REFERENCE ISSUE)** 401
MEDICAL PROGRESS, Prevention of Accidental Falls in Infancy by Counseling Mothers, Harvey Kravitz, 570
MEMBERSHIP FORUM 142, 432
 Merchant, Frederick, Multiloculated Cystadenoma of the Liver 129
 Merckel, Frederick, *jt. author*, Case Report: Pancreatic Transplantation for Diabetes Mellitus (W. G. Ryan, K. Armbruster, S. K. Seim and T. S. Ing) 477
 Meyer, Thomas, **(SPECIAL ARTICLE)** Continuing Medical Education and Professional Growth-The Physician's Protection 217
 Miller, Harry L., *jt. author*, Confusing Urinary Bladder Defects and Configurations (C. Ney) 120
 Mini Editorial **(EDITORIAL)** T. R. Van Dellen 148
 Mullin, Randall, *jt. author*, **(TRAUMA CENTER)** Traumatic Rupture of Thoracic Aorta (E. Sharp and W. Cox) 56
 Mulrooney, James, *jt. author*, Measles in Suburban Cook County (Rasmussen) 576
 Multiloculated Cystadenoma of the Liver (F. Merchant) 129

N

NEW PHARMACEUTICAL SPECIALTIES (Paul De Haen) 48, 146, 230, 428, 580
 Ney, Charles, *jt. author*, Confusing Urinary Bladder Defects and Configurations (H. L. Miller) 120
 Nonketotic Hyperglycemic Coma In Infancy (Ronald Greenwood, Howard Traisman, Mathew Steiner, and Sirus Hadawi) 37

O

OBITUARIES 72, 165, 251, 437, 615
 Officers of County Medical Societies **(REFERENCE ISSUE)** 328

P

Pancreatic Transplantation for Diabetes Mellitus: Case Report (F. Merkel, W. G. Ryan, K. Armbruster, S. K. Seim, T. S. Ing) 477
 Patel, Chandu, *jt. author*, **(PEDIATRIC PREPLEXITIES)** Visceral Larva Migrans (Hletko and Seeler) 574

PEDIATRIC PERPLEXITIES

- Accidental Ingestion (Seeler) 34
Repeated Bouts of Pneumonitis Cough With Feeding & Abdominal Distention (Firor) 134
Idiopathic Pulmonary Hemosiderosis Anemia & "Pneumonia" (Seeler) 421
Visceral Larva Migrans (Hletko, Patel and Seeler) 574
"Physician's Bill of Rights" (**PRESIDENT'S PAGE**) Willard C. Scrivner 464
Physician Recruitment Program 78, 162, 258, 435, 523, 614
Pizzano, Winifred Ann, *jt. author*, (**TRAUMA CENTER**) Illinois Emergency Medical Service System Status Report II (D. R. Boyd, *et al*) 210
Post, Melvin, *jt. author*, Febrile Reaction of Gaucher's Disease (A. Billings and C. Shapiro) 222
PRESIDENT'S PAGE (Scrivner) 21, 97, 182, 299, 464, 543
Prevention of Accidental Falls in Infancy by Counseling Mothers (**MEDICAL PROGRESS**) Kravitz 570
PULSE OF THE DOCTORS WIFE (Rosanne Frank, Editor) 69, 152, 246, 426, 602

R

- Rabies Prophylaxis-A Primer, (Robert J. Rubin) 27
Radiation Enteritis (**SURGICAL GROUND ROUNDS**) (Beal) 567
Rasmussen, Colette, *jt. author*, Measles in Suburban Cook County (Mulrooney) 576
Rheumatology in Chicago, The Story of (Eugene F. Traut) 67
Ryan, Well G., *jt. author*, Case Report: Pancreatic Transplantation for Diabetes Mellitus (F. Merkel, K. Armbruster, S. K. Seim and Toff Ing) 477
Rubin, Robert J., Rabies Prophylaxis-A Primer 27

S

- Sarma, P. S. B., *jt. author*, Drug Treatment of Hyperactivity in Children (M. Falk) 117
Schnurrenberger, Paul R., Studies of Histoplasmosis in Two Illinois Communities 30
Scrivner, Willard C., (**PRESIDENT'S PAGE**) 21, 97, 182, 299, 464
Seeler, Ruth Andrea, Editor, (**PEDIATRIC PERPLEXITIES**)
Accidental Ingestion (seeler) 54
Repeated Bouts of Pneumonitis Cough With Feeding & Abdominal Distention (Firor) 134
Idiopathic Pulmonary Hemosiderosis Anemia & "Pneumonia" (Seeler) 421
Visceral Larva Migrans (Hletko, Patel and Seeler) 574
Seifert, Martin H., The Use and Abuse of Antibiotic and Chemotherapeutic Remedies 64
Seim, Sandra K., *jt. author*, Case Report: Pancreatic Transplantation for Diabetes Mellitus (F. Merkel, W. G. Ryan, K. Armbruster, and T. S. Ing) 477
Selecting Medical Students, (**EDITORIAL**) (T. R. Van Dellen) 238
Sharp, Edward H., *jt. author*, (**TRAUMA CENTER**) Traumatic Rupture of Thoracic Aorta (W. Cox and R. Mullin) 56
Shapiro, Charles, *jt. author*, Febrile Reaction of Gaucher's Disease (A. Billings and M. Post) 222
Statewide System for Post Traumatic Renal Failure (**TRAUMA CENTER**) George Dunca 137
Stein, Leonard S., (**SPECIAL ARTICLE**) Are You Satisfied With Your CME? 499
Steiner, Mathew M., *jt. author*, Nonketotic Hyperglycemic Coma in Infancy (R. Greenwood, H. Traisman and S. Hadawi) 37
Strohl, E. Lee, *jt. author*, (**SPECIAL ARTICLE**) Herman von Helmholtz 1821-1894 Physician, Musician and Versatile Scientist (W. G. Diffenbaugh and R. W. Jamieson) 240

- Studies of Histoplasmosis in Two Illinois Communities, W. Buell, F. Tosh, R. Martin, P. Schnurrenberger, (N. Rose) 30
Surgery and Anticoagulation Therapy (R. A. Dieter, G. H. Asselmeier and R. M. McCray) 205
SURGICAL GRAND ROUNDS, John M. Beal, Editor
Ulcer Recurrent After Vagotomy and Pyloroplasty 41
Gas Infection of Thigh 131
Gunshot Wound of the Back 227
Gastric Leiomyoma 418
Bronchogenic Cysts 484
Radiation Enteritis 567

T

- The Story of Rheumatology in Chicago, (Eugene Traut) 67
"The Way to A Man's Heart Attack" (Richard J. Jones) 123
The Physicians Protection, Continuing Medical Education and Professional Growth (**SPECIAL ARTICLE**) 217
Tobias, Eli, *jt. author*, An Unusual Presacral Tumor (F. Weiss and C. F. Vallejes) 473
Tosh, Fred E., *jt. author*, Studies of Histoplasmosis in Two Illinois Communities 30
Traisman, Howard, *jt. author*, Nonketotic Hyperglycemic Coma in Infancy (R. Greenwood, M. Steiner and S. Hadawi) 37
Tan, Kong Meng, (**SPECIAL ARTICLE**) Foreign Trained Physicians in Illinois 555
Traumatic Rupture of Thoracic Aorta, (**TRAUMA CENTER**) E. Sharp, W. Cox, and R. Mullin) 56
Treatment of Accessible Malignancy Tumors by Irradiation (J. Ernest Breed) 562
Traut, Eugene F., The Story of Rheumatology in Chicago 67
TRAUMA CENTER
Traumatic Rupture of Thoracic Aorta (E. Sharp, W. Cox and R. Mullin) 56
A Statewide System for Post Traumatic Renal Failure (George Dunca) 137
Illinois Emergency Medical Service System Status Report II (D. R. Boyd and Winifred Ann Pizzano) 210
Trustee Districts (**REFERENCE ISSUE**) 334

U

- Ulcer Recurrence After Vagotomy and Pyloroplasty (**SURGICAL GRAND ROUNDS**) 41
Use and Abuse of Antibiotic and Chemotherapeutic Remedies, Martin H. Seifert 64

V

- Vallejes, C. F., *jt. author*, An Unusual Presacral Tumor (F. Weiss and E. Tobias) 473
Van Dellen, T. R., (**EDITORIALS**)
Why Go To Medical School 55
License Renewal 148
Mini Editorial 148
Selecting Medical Students 238
How Not to Get Physicians 000
VIEWBOX (Leon Love) 36, 128, 244
Vithayasai, Vicharn, *jt. author*, Allergic Aspergillosis in a Family (Hyde and Floro) 564

W

- Weiss, Frederick, *jt. author*, An Unusual Presacral Tumor (C. F. Vallejes and E. Tobias) 473
"Where Have All the Doctors Gone?" Charles J. Jannings III (**SPECIAL ARTICLE**) 493
Wingate, Martin B., *jt. author*, Delayed Ovulation (W. S. Arrata and L. Iffy) 44
Wright, Robert, *jt. author*, Celiac Artery Aneurysm (G. Best and R. DeBord) 208

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington, 61701, 309-828-6051. (1)

BLUE ISLAND: Gastroenterologist, Ophthalmologists and Otolaryngologist urgently needed in this south suburban community. City of approx. 20,000, but hospital and clinic serving approx. 250,000. Pronger-Smith Clinic, old, well-established clinic in beautiful new building. Generous starting salary. Contact: Gerald A. Caress, 2320 W. High St., Blue Island, 60406, 312-388-5500. (2)

BRADLEY: Looking for replacement (male or female) in my general practice. Fully equipped including competent personnel. Open staff hospital privileges. Leaving for health reasons. Trade area of 90,000, 60 miles south of Chicago. Write Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CHICAGO: Young multispecialty group with 4 locations. 24 physicians at present. Need Family Physicians or General Internists. Hospital appointments assured. Financial reward commensurate with effort. Opportunity to grow with group. Contact: Dr. Arthur Kunis, 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (2)

CHICAGO: Openings for Medical Specialists and General Practitioners. We are seeking clinicians and supervisors to provide comprehensive health care to City residents through network of Neighborhood Health Centers. Competitive salaries, complete fringe benefits. Contact Mr. Gerald O'Sullivan, Personnel Office, Board of Health, Civic Center, Chicago, 60602, 312-744-3805. (3)

CHICAGO: Internist; an insurance company has an opening for the position of staff physician in its medical department. Full-time, fringe benefits, salary negotiable, office population. Contact: Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago, 60601. (12)

CLINTON: General Practitioners needed for rural community. Population 8,000. 50 bed JCAH hospital. Located 25 miles from Bloomington and Decatur and 40 miles from Springfield. This community offers good schools and educational opportunities, recreational areas, and shopping areas within a short distance. Medical Staff needs your help. Contact: Dr. Charles Ramey, 215 East Main Street, Clinton, 61727, 217-935-2191. (12)

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Obituaries

***Cahan, Meyer**, Chicago, died at the age of 70 on October 11. Dr. Cahan graduated in 1940 from the University of Illinois College of Medicine. He was active in medical research and teaching and was a member of the Weiss Memorial Hospital staff.

Hartman, Perry V., Jr., died October 3, at the age of 67. He had been honored at St. Margaret's Hospital for having served 39 years in the medical profession and as a staff member of the hospital.

***Hennet, James H.**, Macomb, died October 17, at the age of 71. He was a graduate of Knox College and Johns Hopkins Medical School. He began his practice in 1930 and was head of the Marrietta Phelps Hospital and a member of the surgical staff at McDonough District Hospital. He also was past president of the McDonough County Medical Society.

****Hiatt, Homer**, Beecher, died October 27, at the age of 80. He was the founder of the Hiatt Clinic and co-founder of South Suburban Hospital. He also was the first recipient of the "Citizen of the Year Award." Dr. Hiatt graduated in 1917 from the Chicago College of Medicine and Surgery, now Loyola University Stritch School of Medicine. He had been a physician for more than 50 years.

***Krant, Harry**, Chicago, died October 29, at the age of 69. He was on the staffs of the former Lutheran Deaconess and Northwest Hospitals. He graduated in 1928 from the University of Illinois.

****Lerner, Samuel**, Chicago, died October 28, at the age of 77. He was the founder of the Roosevelt Memorial Hospital and professor emeritus at Chicago Medical School. Dr. Lerner graduated in 1922 from the University of Chicago, Rush School of Medicine. He had been a physician for more than 50 years.

***Riley, John Samuel, Jr.**, Lovejoy, died July 6, at the age of 47. He graduated in 1951 from the Howard University School of Medicine.

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